

Bauhinia Foundation Research Centre

**An Analysis of the Managed Care Market
in Hong Kong**

Executive Summary

Public Policy Research Institute
The Hong Kong Polytechnic University

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INTRODUCTION

In July 2006, the Bauhinia Foundation Research Centre commissioned the Public Policy Research Institute (PPRI) of The Hong Kong Polytechnic University (University) to survey and analyze the existing managed care market in Hong Kong. This Executive Summary summarizes the major findings of this Study.

For this Study, managed care is defined as any health care financing system in which employers and purchasers of health care services contract the delivery of service with a provider organization (or through a third party) based on capitation or other pricing mechanisms other than simple fee-for-service. Managed Care Organizations (MCOs) are sometimes referred to as Health Maintenance Organizations (HMOs), contract medicine, panel doctors or medical networks.

METHODOLOGY OVERVIEW

This Study began with a search of archival data on MCOs in Hong Kong. Field visits to clinics located in selected commercial and residential districts were undertaken to ascertain the extent of doctors' involvement in managed care arrangements. Focus group discussions and interviews with managed care providers – insurance companies, brokers, medical groups and individual doctors – and managed care consumers – employers and individual employees – were conducted. Two Case Studies involving the entire 'supply-demand chain' were carried out. Finally, all doctors in Hong Kong were surveyed to determine the nature and extent of their involvement as well as their views on the way forward. The results of the qualitative inquiries served as input for the design of a questionnaire survey of doctors and to triangulate the results of the questionnaire survey.

QUALITATIVE DATA ANALYSIS

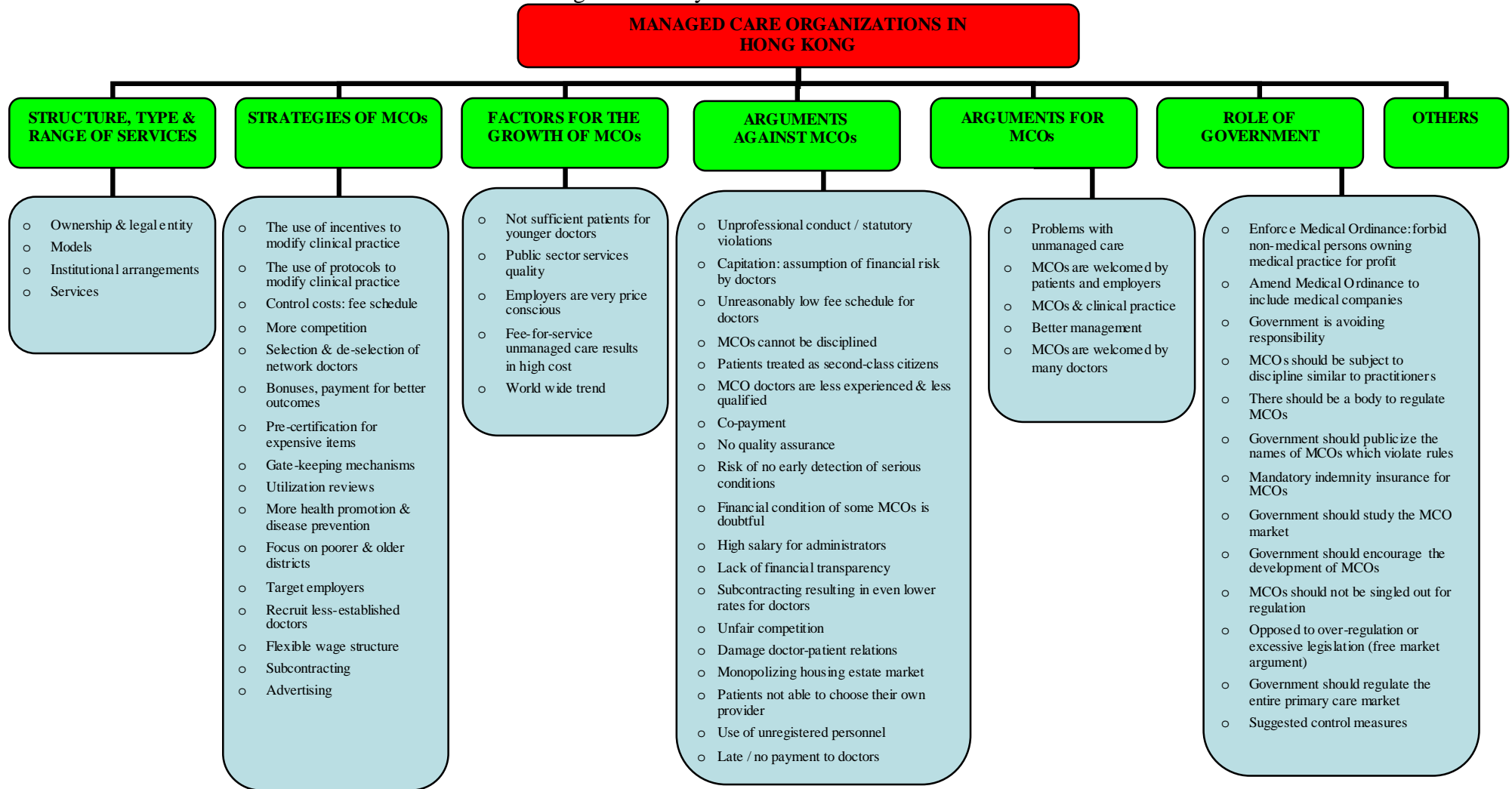
A Grounded Theory¹ approach was adopted for analysis of all the qualitative data. The data comes from the following sources:

- archival data (academic articles, Health and Medical Development Advisory Committee papers, Legislative Council papers, press reports and commentaries)
- responses to the open-ended questions to the questionnaire survey
- direct observations of practitioners' clinics in relation to the acceptance of medical cards
- interviews of key stakeholders
- two case studies focusing on the "supply-demand chain"
- findings from the Department of Health Working Group (2006)

Based on the views contained in the above sources, an Analytical Framework was constructed comprising a hierarchy of themes and categories. It was revised several times to ensure comprehensive coverage of all the views collected. All views were cross-referenced by category and source group. The Framework is shown in Figure 1.

¹ A research approach which allows data to influence the methodological framework.

Figure 1: Analytical Framework



NUDIST (Non-numerical Unstructured Data Indexing Searching and Theorizing), a qualitative data analysis computer software, was employed to analyze, organize and summarize documents, written submissions and verbal comments collected according to specific categories within the Analytical Framework. NUDIST treats each sentence, or a group of related sentences, expressing a particular view as one “text unit”.

Summary of Results

The salient points of the top 15 categories, in terms of frequency counts of text units, are presented in the following paragraphs.

Two related categories received most attention among stakeholders: “there should be a body to regulate MCOs” (ranked no.1) and “unprofessional conduct: statutory violations” (ranked no.2). Stakeholders tend to believe that in order to address the latter problem a regulatory body has to be established.

In relation to the regulatory body, there is a widespread call to set up a body to set rules and standards for MCOs. Such body could be set up by the Hong Kong Medical Council or the Department of Health or other relevant body. It should include both the health authority (concerning the quality of medical service) and the insurance authority (concerning financing and underwriting matters). It should look into such issues as the quality assurance system, disclosure of fees, professional autonomy, contractual terms, patients’ rights, medical ethics, capital requirement, advertising and other deliverables.

The alleged unprofessional conduct (mostly from the printed media) which may have violated medical legislation includes (a) performing unnecessary treatment on patients to generate income, (b) forcing dentists to sell expensive and unnecessary dental work for fees, (c) barring doctors from prescribing the best treatment to patients, (d) forcing doctors to perform duties beyond their abilities, (e) requiring doctors to buy dangerous drugs for MCOs, (f) altering prescriptions without the doctor’s knowledge, (g) using unregistered medicine or vaccines, (h) infringing doctors’ autonomy, and (i) contravening the code of conduct in canvassing customers or advertising misleading information.

There is some criticism of MCOs’ “late / no-payment” to network or affiliated doctors (ranked no.3). This is revealed especially in doctors’ open-ended answers to the questionnaire survey, although close-ended statistics indicate a low incidence of occurrence. A delay of 3 to 6 months is not uncommon. When expensive and long-term medication is involved, the collection of fees can be extremely tedious and time consuming.

Notwithstanding the criticisms against them, “MCOs are welcomed by patients and employers” (ranked no.4). In Legislative Council papers and interviews with stakeholders particularly, the advantages of MCOs are clearly presented: (a) MCOs are able to compete on prices and services, (b) MCOs have the ability to reduce abuses and increase cost-effectiveness, (c) MCOs provide a predictable budget for employers, (d) some MCOs do exercise some quality assurance measures within their network.

The press has reported extensively on the issue of “advertising” (ranked no.5). Apart from a few reports favouring consumers rights, most reports focus on the negative side of MCO advertising such as luring people to join discounted medical schemes.

From the interviews with stakeholders, the different operating “models” (ranked no.6) of the MCOs are explained: staff model, group model, independent practice association, preferred providers organization and point-of-service model. Some MCOs are corporate medical administrators. The MCO landscape in Hong Kong is extremely complex.

Again, from the interviews, stakeholders explain the different types of “services” (ranked no.7) in the managed care market. These services include GP-only services, GP and specialist outpatient services, diagnostic services, physiotherapy, hospitalization, alternative medicine, laboratory tests, radiology, chiropractic services and traditional Chinese medicine. The services are often tailor-made to suit the clients.

Under the category of “suggested control measures” (ranked no.8) relating to the role of Government, stakeholders propose that (a) an MCO’s board of directors should be made up of doctors, (b) only defined MCOs should be able to operate capitated health plans, (c) there should be a limit to the size of corporate ownership, and (d) the industry should regulate itself.

From the interviews, stakeholders also elaborate the technical and often nuanced “institutional arrangements” (ranked no.9) of the managed care market. These arrangements include: fixed-salaried doctors, fee-for-service, capitation, salary plus bonus, profit-sharing and some or all of the above. While fee-for-service remains the norm for private medicine in Hong Kong, prepaid capitation schemes underwritten by insurers are becoming more acceptable in the managed care market.

The call to “amend the Medical Registration Ordinance to include MCOs” (ranked no.10) receive some attention in academic journal articles, the press and stakeholder interviews. In particular, a legislative loophole is pointed out in that the Ordinance is only concerned with medical practitioners and has no jurisdiction over MCOs which are run by businessmen or administrators who are not medical practitioners.

In the category “ownership and legal entity” (ranked no.11), three major types of group practice are identified: group medical, incorporated medical practice and MCO-insurance partnership. Other types also exist. In terms of ownership, MCOs can be owned by an insurance company, an insurance broker, a group of doctors or a business firm.

From the Questionnaire Survey, respondents criticise the “unreasonably low fee schedule for doctors” (ranked no.12). The fee can be under \$50 per consultation. This arrangement forces network doctors and dentists to see as many patients as possible. It also limits the doctor’s choice of medicine to the cheapest generic substitutes. Some call for a fair minimum consultation charge for doctors.

Given the alleged abuses in the managed care market and the obvious legislative loophole, some propose that “MCOs should be subject to discipline similar to

practitioners” (ranked no.13). Such views are reflected in the press and the Questionnaire Survey.

From the Questionnaire Survey results, some hold the view that MCOs, because of their profit orientation, will tend to compromise quality (ranked no.14). Low satisfaction ratings in some contract medicine arrangements in Hong Kong have been reported in an academic journal article.

Some hold the view that there is a need to “enforce the Medical Registration Ordinance: forbid non-medical persons owning medical practice for profit” (ranked no.15). Suggestions made include: (a) healthcare partnerships modeled on lawyers’ and accountants’ partnerships (with at least 90% registered doctors participation), and (b) all MCOs should be non-profit making bodies and the middleman-type MCOs should be disallowed.

Other salient points include problems associated with capitation payment for doctors, subcontracting of doctors, high costs of having middlemen and administrators, lack of financial transparency of MCOs, untruthful and misleading advertising by some medical card companies, a medical card company went bankrupt, and network patients treated as second-class citizens. There were also comments about the problems of “unmanaged care”, the under-regulated primary care in general, and the costs associated with excessive regulation.

FIELD VISITS TO CLINICS

Field visits to clinics in selected commercial and residential districts were undertaken to ascertain the extent of doctors’ involvement in managed care arrangements. A display of medical cards for managed care schemes to which the doctors belong was considered prima facie evidence of their acceptance. A count of the number of cards was recorded. If no medical cards were displayed, the nurse or the person in charge of the clinic was then asked if the clinic accepted medical cards or not, and the result was recorded.

While the field visits did not cover all districts in Hong Kong nor all clinics in the districts visited, the visits were intended to include clinics situated in various types of commercial-residential districts or commercial buildings with a preponderance of medical clinics in them:

- Residential districts with large public housing estates such as Ngau Tau Kok, Wong Tai Sin and Yuen Long
- Residential districts with mixed public/private housing such as Fanling/Sheung Shui, Shum Shui Po, Kennedy Town and Hung Hom
- Primarily private housing districts such as Taikooshing, Jordan Road (Champion Building), Nathan Road (ground-floor clinics)
- Business and commercial districts such as Causeway Bay (Hang Lung Centre) and Central (Melbourne Plaza)

The survey shows the following:

- More GPs (71%) than specialists (32%) accept medical cards
- Half of the doctors (50%) (GPs, specialists and specialists working as GPs) in residential districts (all except Central and Causeway Bay) accept medical cards
- Very few doctors (1%) in the business and commercial districts (Central and Causeway Bay) accept medical cards
- In general, established doctors in the business and commercial districts can afford to work without accepting medical cards.

CASE STUDIES OF THE “SUPPLY-DEMAND CHAIN”

This Study examines two cases involving MCOs – two rather large anonymized organizations with thousands of employees and dependents. While both organizations provide health benefits to employees through MCOs, the configuration of the two plans and their level of benefits are quite different. The entire “Supply-Demand” chain for each of the organizations was examined with a view to (a) illustrating how managed care operates in an employer-based plan situation, and (b) examining if differences in institutional arrangements would make a difference in the satisfaction level of different stakeholders, end-users in particular. On the supply side, insurance companies, provider groups and selected panel doctors were interviewed. On the demand side, focus group discussions and interviews were conducted for human resource managers and different grades of employees. Consumer satisfaction was examined in terms of access, financial protection, technical quality, communication with doctor, choice of doctors, outcomes and handling of complaints.

Organization A

The Organization provides a rather comprehensive package of health benefits to its staff and their direct family members. It has a contract with a major insurance company, insuring staff and their dependents against both outpatient and inpatient expenses. Annual outpatient benefits include: up to 50 general practitioner’s visits, \$200 per visit (inclusive of medicine and without co-payment); up to \$5,400 for specialist consultations; \$4,200 for investigations; up to \$300 for vaccinations; and up to \$300 for pap smears. Annual inpatient benefits include: up to \$72,000 for surgeon’s fee per episode for senior staff and up to \$55,000 for general grade staff; up to \$1,050 per day for hospital room for senior staff and up to \$560 per day for general grade staff, up to 280 days; full refund of miscellaneous hospital charges; up to \$1,050 per day for doctor’s hospital visits for senior staff and up to \$560 for general grade staff, up to 280 days.

The insurance company contracts with a large number of providers, including general practitioners and specialists in solo practice, as well as a number of medical groups. There are over 880 doctors in the network, offering credit facilities to staff and dependents holding the membership card. The card is also recognized by almost all private hospitals in Hong Kong. Staff and dependents can visit doctors outside the list, and have expenses, up to \$200 per visit, reimbursed by the insurance company. The insurance company also has a services hotline and a worldwide emergency aid hotline for its customers. The annual premium for each beneficiary (staff plus eligible

dependents) is around \$6,000. The insurance company reimburses network providers on a fee-for-service basis according to an agreed fee schedule. For services rendered outside the network, the insurance company reimburses staff and eligible dependents directly according to a benefit schedule. Individual providers belonging to a medical group would be compensated according to the agreement between the providers and the group. This could be fixed salary, discounted fee-for-service or other arrangement.

Organization B

The Organization contracts directly with three medical groups for the provision of primary care services for its staff (and family members of more senior staff). The organization self-insures and does not engage any insurance companies, brokers or other intermediaries for the provision of health benefits. Annual outpatient benefits include: up to \$110 per GP visit and \$220 for specialist visit (including medicine and without co-payment) up to a maximum limit of \$5,000 per year. Staff can use specialists outside the three networks and have their expenses reimbursed by the company. More senior staff have the same spending limit of \$5,000, but enjoy greater flexibility – no dollar limit per visit and eligibility for family members. The contracted medical groups provide hotlines for staff enquiries. They also organized occasional health talks for staff and provided check-ups and vaccination at a discount rate. Annual inpatient benefits include: \$110 or \$160 per day for hospital room and board; \$4,000 or \$6,000 for surgeons fee and other expenses per episode; total spending per disability not exceeding \$20,000 or \$30,000, depending on grade. The company is totally self-insured for staff inpatient benefits and does not use any insurance companies or other intermediaries. Many staff purchase top-up plans on their own. For the contracted services with three medical groups, each group has a number of clinics and a wide network of several hundred affiliated providers, including GPs, specialists, dentists, Chinese medicine practitioners, laboratories and physiotherapy centres. Duration of contract is normally one year. Staff can visit doctors outside the three networks and have expenses, up to \$110 or \$115 per visit, reimbursed by the human resource office depending on grade.

The providers are compensated on a discounted fee-for-service basis (\$110 or \$115 per visit for GPs including medicine). Specialists on the list offer a discount rate to cardholders. None of the groups or their affiliates is compensated on a capitation basis. All of the contracted clinics extend credit facilities to card holders. The group's information system allows clinics to alert staff if their spending level is close to the limit.

Findings

The two Case Studies did not reveal any serious problems in the provision of primary care services for the two organizations. The providers – the MCOs and the doctors – were satisfied with the contracts. The human resource manager in Organization A was happy with the predictable budget and the ease of administration. Since no intermediaries were engaged, the manager in Organization B was more involved in the administration of her organization's health schemes, but she was still quite satisfied with the arrangement.

Organization A's plan is a capitation plan, even though the majority of the providers are paid on a fee-for-service basis. The insurance company also acts as the intermediary between the organization and the providers. MCO critics often blame capitation as a source of dissatisfaction. The intermediary is also seen as a middle man taking huge profits from the doctors.

Organization B's plan is a discounted fee-for-service plan. The organization contracts directly with the medical groups, without any middle man.

While staff of both organizations were quite satisfied with the credit facilities and the availability of a large number of providers, Organization A's staff were definitely more satisfied than Organization B's. When asked (using 31 questions) specifically about their satisfaction in terms of access, financial protection, technical quality, communication with doctor, choice of doctors, outcomes and handling of complaints, the two groups of staff appeared to be equally satisfied regarding convenience of location of doctors, their opening hours and the number of doctors to choose from. The remaining 28 questions asked – ease of seeing a specialist, ease of admission to hospital, access to emergency care, ease of getting the needed medicine from the doctor, convenience of getting lab tests, convenience of getting X-rays, availability of medical information by phone, convenience of getting medical care (locally at anytime), convenience of getting medical care overseas, waiting time to see a doctor, appointment waiting time, protection against hardship due to medical expenses, arrangements to get care without financial problems, arrangements to get extra care with extra payment, thoroughness of examinations, skill and experience of doctors, doctor's explanation of procedures and tests, attention given by doctor, advice from doctor about staying healthy, ease of seeing the doctor, friendliness and courteousness of the doctor, amount of time with the doctor, the outcome of care, overall quality of care, time spent to lodge a complaint through the clinic, satisfaction about complaint, time spent to lodge complaint through human resource department and satisfaction about complaint – indicated that staff from Organization A were much more satisfied than those from Organization B.

The explanation appears to be simple – the consultation fee (i.e. amount paid to the doctor) for Organization A is \$200, compared to \$110 for Organization B. This suggests that fee schedule is important in affecting consumers' perception of plan quality as well as their satisfaction level. Capitation and the existence of intermediaries do not appear to affect satisfaction level, so long as the premium and the resulting fee schedule are sufficiently high.

DEPARTMENT OF HEALTH WORKING GROUP (2006)

A Working Group was set up by the Department of Health in April 2006 to study the HMO/MCO issues and to collect views from various stakeholders. The study concluded that HMOs/MCOs in Hong Kong comprise a group of highly heterogeneous organizations relating to primary health care services in the private sector. They include group medical practices and scheme administrators.

The Working Group found that purchasers and users, in general, reckoned that MCOs have brought benefits in terms of choice, affordability, physical and time accessibility,

comprehensiveness and quality. They, however, would also welcome more protection of their welfare.

The Working Group also found that professional bodies were concerned that MCOs' interests might compromise patients' welfare and the autonomy of health care professionals. There were also allegations of unprofessional practices in some MCOs, such as the dispensing unregistered drugs, and the alteration of prescriptions without the consent of the employee doctors.

SURVEY ON DOCTORS

The qualitative data as described identified certain issues: the mode of operation of doctors involved in MCOs; the size of the MCO market; the characteristics of providers involved in MCOs; mode of compensating service providers; the fee differential between regular patients and network patients; how patients are billed and fees are collected; existence of undesirable practices; existence of desirable practices; and view of doctors regarding the regulation of MCOs. These issues served as input for the questions asked in the questionnaire survey.

Survey Methodology

Two rounds of questionnaires were sent out. In the first round, 10,158 questionnaires were mailed during 20-22 October 2006 to all doctors registered with the Medical Council of Hong Kong as at 5 August 2005. 1,013 responded to the survey, giving an overall response rate of around 10%. A second round of questionnaires was mailed, during 18-19 December 2006, to the doctors who failed to respond to the first round. There were 209 replies from the second round. The overall sample size was 1,222, and the overall response rate of 12.4%. A statistical test was performed to test if significant difference exists between this sample and a much larger sample of the Government 2003 Health Manpower Survey in terms of the percentage of private doctors in solo practice. No significant difference was found.

Summary of Results

Participation Rate: The majority of doctors participate in networks, with the percentage being higher for those in group practice (64%) than in solo practice (58%). Solo practitioners also tend to be associated with fewer networks (mean = 3.64) than group practitioners (mean = 5.80). Most network contracts are of 1-2 years' duration.

Characteristics of Doctors: Doctors with less than 10 years' experience are more likely to work in groups, whether networked (44%) or non-networked (35%). Doctors with more than 20 years' experience tend to be in solo practice (69%) or practice solo within a network (46%). This is logical, given that well-known specialists are able to rely on their reputation to bring in sufficient fee-for-service patients, whereas association with a group or network assists new doctors to find patients. Other reasons for this phenomenon may be pragmatic and economic – it is easier and cheaper for a new doctor to join an established group practice than to set up and run his/her own clinic.

Compensations: While most doctors (61% of GPs and 90% specialists) are compensated for their work on a fee-for-service basis, GPs are more likely than specialists to be remunerated on a fixed salary (20%), bonus/pay-for-performance (14%) or capitation (4%) basis.

Network patients account for an average of 18% of networked doctors' income, (mean = 22% for GPs and 14% for specialists). Again, this supports the view that well-established doctors are better able to rely on their reputation to bring in fee-for-service patients. Doctors receive significantly lower fee-for-service payment for seeing network patients compared to regular patients – typically 29% to 50% less for consultations and around 24% less for office procedures. Only 10% of networks reimburse doctors for delivering preventive/detection services.

Billings: Doctors bill their network patients by various means – through insurance companies (50%), medical group (48%), third party administration organizations (33%) or the patient's employer directly (17%). Only a minority of doctors (17%) experience frequent problems collecting fees from their associated MCOs.

Restrictions: Organizationally, doctors working in networks and in group practices are subject to varying degrees of restrictions and guidelines – 58% have restrictions on referrals to certain specialists, 51% have laboratory and/or imaging tests they cannot order, 48% have guidelines on prescribing expensive drugs, 31% are subject to utilization reviews, 13% are provided with clinical protocols for certain conditions, and 7% are advised to purchase drugs/vaccines from specified suppliers. Generally, GPs tend to be subject to more direction than specialists.

Facilities and Other Support: Only a minority of networks (31%) give their doctors access to equipment/facilities elsewhere within the network or provide training/development programmes (17%), with GPs benefiting more than specialists.

Views on Government Regulation: Regarding the way forward for managed care organizations, over 80% of doctors were in favour of greater government regulation, in the form of either registration with some regulatory authority (49%) or having a registered doctor as a director on their board (47%).

ANALYSIS OF RESULTS

The paragraphs below integrate the findings from both the quantitative and qualitative data.

(1) Managed Care is a Major Form of Primary Care Delivery

MCOs are ubiquitous in Hong Kong. This Study shows that more than 50% of the doctors in the private sector are involved in managed care in one form or another. They are more prevalent in the residential areas. A significant percentage (over 30%) of these doctors are associated with many networks. Over 35% of these doctors derive over 20% of their income from network patients.

The percentage of doctors involved in MCOs is slightly higher for those in group practice (64%) than those in solo practice (58%). Doctors in group practices tend to

be associated with more networks (mean = 5.80) than those in solo practice (mean = 3.64). Some doctors participate in as many as 90 networks.

Some plans have hundreds of providers participating in the network, with hundreds of thousands of enrolled consumer members.

(2) MCO Landscape: Extremely Diverse

Many different models of MCOs exist in Hong Kong, and huge variations exist within each of the major models. Variations also exist among different schemes within a particular MCO.

MCO “hosts” include insurance companies, insurance brokers, medical groups and third-party administration organizations. These entities may or may not be owned by doctors.

Providers include doctors employed by medical groups and independent practitioners joining MCOs as affiliates.

Discounted fee-for-service is the most common form of payment to solo practitioners (90%) and groups practitioners (47%) under MCO arrangements. Fixed salary is less common and is found mainly in medical groups. Capitation is found in only a small number of cases (3%).

Some MCOs offer a comprehensive range of services, including GP, specialist, dental, physiotherapy, laboratory, imaging and Chinese medicine services. Others are confined to mainly GPs services and limited specialist services.

(3) Concerns About Proliferation of MCOs

This Study clearly shows that doctors are concerned about the proliferation of MCOs.

The competitive pricing strategies of MCOs and the resulting lowering of doctors fees and charges are major concerns to many doctors. Typically, doctors in network arrangement charge 29% to 50% less for consultations and around 24% less for office procedures.

The possible loss of professional autonomy under MCO arrangements, capitation payment for doctors, subcontracting of doctors, high costs of having middlemen and administrators, the lack of financial transparency of MCOs, untruthful and misleading advertising by some medical card companies, medical card companies going out of business, and network patients treated as second-class citizens are causes for concerns.

Solo practitioners view the ability of MCOs to advertise as an unfair advantage.

(4) Considerable Support for MCOs

Many employers and human resource managers find MCO plans attractive because many MCO plans are tailor-made to fit the company’s budget and other requirements.

They are often generally cheaper than conventional open panel fee-for-service insurance plans.

Employees generally like the convenience of credit facilities extended to them, and the often wide choice of providers within the network and outside the network for some plans. Satisfaction level tends to correlate with the premium and the resulting fee levels for providers rather than to the MCO configuration.

MCOs provide sources of patients and associated logistic/administrative support for doctors within their network. Such sources of patients constitute a significant percentage of income for some providers, especially the less established doctors.

A minority of doctors (17%) experience frequent problems collecting fees from their associated MCOs.

(5) Controversial Practices in Some MCOs

Some of the fees charged are unrealistically low, resulting in questionable quality of care being rendered.

Doctors working in networks and in group practices are subject to varying degrees of restrictions and guidelines – 58% have restrictions on referrals to certain specialists, 51% have laboratory and/or imaging tests they cannot order, 48% have guidelines on prescribing expensive drugs, 31% are subject to utilization reviews, 13% are provided with clinical protocols for certain conditions, and 7% are advised to purchase drugs/vaccines from specified suppliers.

(6) Potential Benefits of MCOs Not Fully Pursued

Only a minority of networks (31%) give their doctors access to equipment/facilities elsewhere within the network, provide training/development programmes (17%) or reimburse doctors for delivering preventive/detection services (10%).

This is partly due to the fact that the vast majority of the contracts signed between employers/MCOs and MCOs/providers are of a short duration, normally one year. Such practice is not conducive to MCOs investing in some of the above mentioned areas.

(7) Strong Support for Greater Regulation of MCOs

This Study shows that over 80% of doctors are in favour of greater government regulation, in the form of either registration with some regulatory authority (49%) or having a registered doctor as a director on the MCO's board (47%). This is corroborated by submissions from various doctors associations and press articles.

Some MCOs, however, are of the view that existing regulation is adequate and further regulation is unnecessary. Other MCOs are not against having some regulatory platform for the industry.

There is also a view that private primary care clinics in general – and not just MCOs – should be subject to tighter control.

(8) Corroboration with Findings from the Department of Health Working Group (2006)

The qualitative data collected from various sources and the survey of doctors of this Study, in general, corroborate the findings of the Department of Health Working Group’s study conducted in mid 2006. The following table summarizes and compares the results from the two studies.

ISSUES	DH WORKING GROUP	THIS STUDY
Size of the MCO Market	Rapid development since the late 1990s.	The majority of doctors in the private sector are now involved in managed care.
Models and Involved Parties	HMOs in Hong Kong are group medical practices and scheme administrators. The various involved parties include purchasers (employers), brokers, insurance companies, scheme administrators, incorporated practices and solo practitioner associates. Diverse in terms business model.	Same. Same. Same. Discounted fee-for-service is the most common form of providers’ payment method. Fixed salary and capitation are less common.
Employers’ and Users’ Views	Purchasers and users welcome MCOs in terms of choice, affordability, convenience, comprehensiveness and quality. They also welcome more protection of their welfare.	Same. Users’ satisfaction level correlates with the premium level and the resulting fee levels for providers.

<p>Professional Bodies' Views</p>	<p>Doctors' and dentists' associations are concerned that MCOs' cost containment drive and commercial interests might compromise patient's welfare and providers' professional autonomy.</p> <p>The ability of MCOs to advertise is seen as an unfair advantage.</p>	<p>Same.</p> <p>Typically, doctors in network arrangement charge 29% to 50% less for consultations and around 24% less for office procedures.</p> <p>Same.</p>
<p>MCOs Views</p>	<p>Group practices provide training and education opportunities, clinical protocols, equipment and facilities for their doctors, and a wider scope of services for the consumer.</p> <p>Cost containment and reduction of administrative hassles are welcomed by employers.</p>	<p>Same.</p> <p>Same.</p> <p>MCOs expressed concerns about the problems of "unmanaged care", the under-regulated primary care in general, and the costs associated with excessive regulation.</p>
<p>Individual Doctor's Views</p>		<p>Concerns over capitation payment, subcontracting, high costs of having middlemen and administrators, the lack of financial transparency of MCOs, and network patients treated as second-class citizens.</p> <p>MCOs provide sources of patients and associated logistic/ administrative support for doctors within their network. Such sources of patients constitute a significant percentage of income for some providers.</p>

		<p>Doctors working in networks and in group practices are subject to varying degrees of restrictions/guidelines on referrals, tests, and prescribing expensive drugs. Some are subject to utilization reviews. A small percentage is advised to purchase drugs/vaccines from specified suppliers.</p> <p>Only a minority of networks give their doctors access to equipment/facilities elsewhere within the network, provide training/development programmes or reimburse doctors for delivering preventive/detection services.</p>
<p>Regulatory Options</p>	<p>Diverse views including restricting ownership, registration, and introduction of medical directors to be held accountable for medical decisions in MCOs.</p>	<p>Same.</p> <p>Over 80% of doctors are in favour of greater government regulation, in the form of either registration with some regulatory authority (49%) or having a registered doctor as a director on the MCO's board (47%).</p> <p>Some MCOs are of the view that existing regulation is adequate and further regulation is unnecessary. Other MCOs are not against having some regulatory platform for the industry.</p>

SUMMARY OF FINDINGS

This Study shows that MCOs are a major form of primary care delivery in Hong Kong. The majority of doctors in the private sector participate in MCOs.

Huge variations exist within the managed care industry in terms of the financial strengths of the MCO host, the supply chain configuration (the hierarchy of intermediaries and contracting), the nature of ownership, the size of the MCOs, the range of services offered and the method of compensating providers.

Due to their economies of scale in operation, MCOs are able to provide convenient and cheaper health care services to the general community, employers in particular. The existence of MCOs has enhanced market competition in the provision of primary medical services, and their services are, in general, welcomed by consumers.

The rapid proliferation of MCOs has also aroused concerns from many doctors and doctors associations. They demand that MCOs should be subject to the same controls as individual doctors. This Study confirms this concern.

This Study confirms the existence of a number of controversial practices by some MCOs – utilization reviews, clinical protocols, guidelines on referrals, ordering tests, dispensing expensive drugs, and ordering drugs from specified suppliers. Whether these practices constitute unethical or unprofessional acts require further investigation.

This Study further confirms that doctors receive significantly lower fee-for-service payment for seeing network patients compared to regular patients. Consumer satisfaction appears to be correlated to the level of fee payment to doctors.

There is consensus amongst doctors that greater government regulation, in the form of either registration with some regulatory authority or having a registered doctor as a director on their board, is desirable. The Consumer Council suggests a code of conduct be drafted and implemented for MCOs.

This view is not shared by many MCOs, which are of the opinion that existing legislation is adequate to safeguard public interest.

Potential benefits of MCOs – such as shared equipment and facilities among network doctors, more emphasis on prevention and early detection, 24 hours clinics, training and development opportunities – are not fully realized in many MCOs in Hong Kong.

This Study, in general, corroborates the findings of the Department of Health Working Group's study conducted in mid 2006.