CHAPTER 5

Hospital Authority

Health, Welfare and Food Bureau

Hospital Authority:
management of outstanding medical fees

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HOSPITAL AUTHORITY:
MANAGEMENT OF OUTSTANDING MEDICAL FEES

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PART 1: INTRODUCTION

1.1 This PART describes the background to the audit and outlines the audit objectives and scope.

Background

Hospital Authority

1.2 The Hospital Authority (HA) is a statutory body established in December 1990 under the Hospital Authority Ordinance (Cap. 113) to manage all public hospitals (hereinafter referred to as hospitals) in Hong Kong. It is governed by the HA Board that consists of a chairman and more than 20 members appointed by the Government. The Chief Executive, HA is responsible for the overall management of the HA's day-to-day operations under the policy direction of the HA Board.

1.3 As at 31 March 2006, the HA employed 52,000 staff and managed 41 hospitals and institutions. These hospitals and institutions are grouped into seven clusters to enhance the coordination, planning and management of medical services. Hospitals and institutions in each cluster complement and support one another through cross-referral of patients, and sharing of major medical equipment and other clinical support services. Each cluster is headed by a Cluster Chief Executive and each hospital is headed by a Hospital Chief Executive (HCE).

Fee structure

1.4 For the financial year 2006-07, the Government's recurrent subvention to the HA is estimated to be $27,761 million. The HA is accountable to the Government through the Secretary for Health, Welfare and Food.

1.5 Under the existing system of medical fees and charges (hereinafter referred to as fees — Note 1), eligible persons (EPs) are entitled to use public medical services which are heavily subsidised at about 96% of the full cost. EPs are:

Note 1: *The Hospital Authority Ordinance stipulates that the Secretary for Health, Welfare and Food may give directions to the HA to determine the fees payable for its medical services. The last fee revision was gazetted in September 2005.*

(a) holders of the Hong Kong Identity Card; or

(b) children who are Hong Kong residents and under 11 years of age; or

(c) other persons approved by the Chief Executive, HA.

Non-eligible persons (NEPs — i.e. persons who are not EPs) have access to public medical services. However, they have to pay fees set on a full-cost recovery basis. Both EPs and NEPs can obtain medical services as private patients (Note 2) from hospitals. These services are charged at the market rate which should at least be at full cost.

Assistance to patients with financial difficulties

1.6 In the provision of public medical services, the government policy is that no one will be denied adequate medical care due to lack of means. To uphold this policy, recipients of Comprehensive Social Security Assistance (CSSA) are entitled to free medical treatment at hospitals. For patients who are not CSSA recipients but have difficulties in paying fees, the HA and the Social Welfare Department have jointly put in place a fee waiver mechanism to provide them with protection from undue financial burden. Under the mechanism, patients may approach Medical Social Workers stationed in the Medical Social Services Units of hospitals to apply for fee waivers.

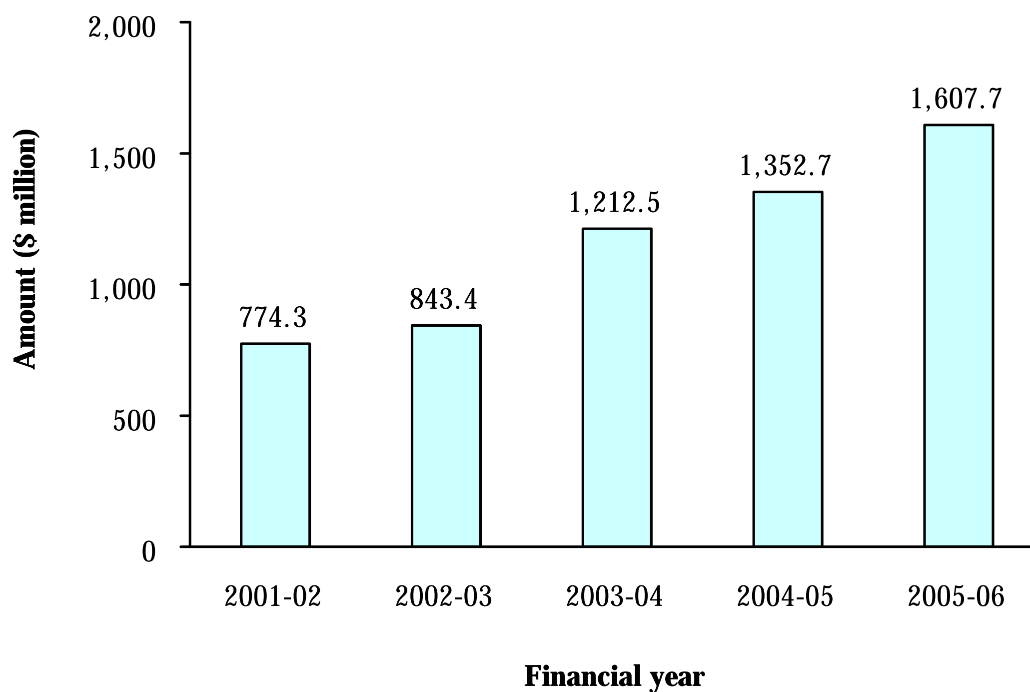
Collection of fees at hospitals

1.7 The Shroff Office is responsible for collecting fees from patients. Figure 1 shows the fee income of the HA from 2001-02 to 2005-06.

Note 2: *There are levels of expertise and facilities within the public medical sector (especially at the teaching hospitals) which are not generally available in the private medical sector. Medical services for private patients therefore provide a means for accessing such expertise and facilities.*

Figure 1

Fee income of HA
(2001-02 to 2005-06)



Source: HA records

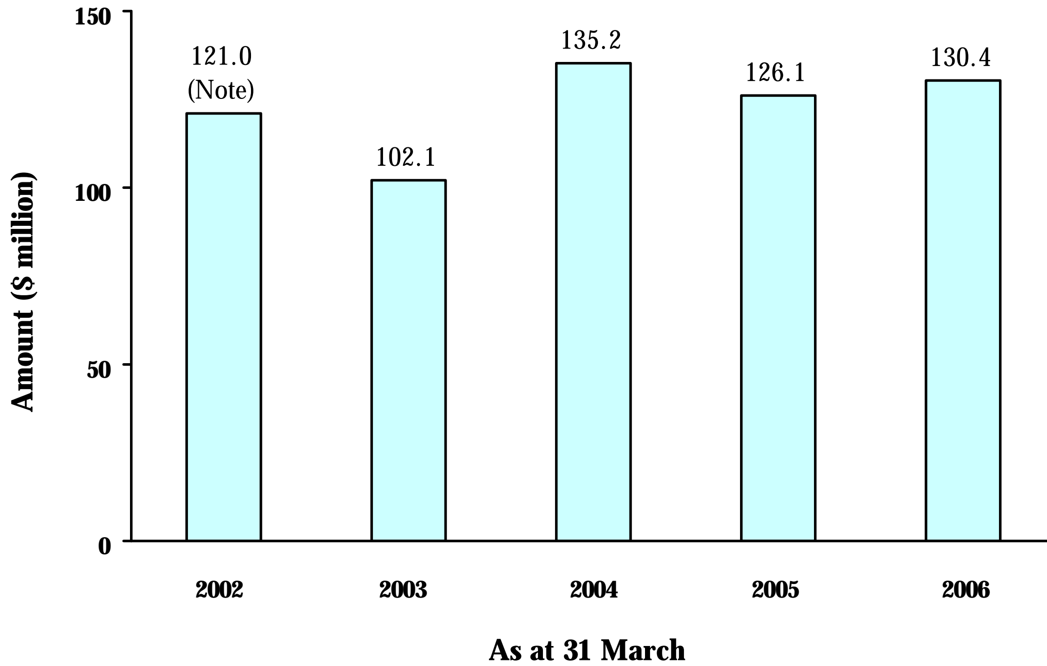
Note: The fee income of the HA does not include the amount of fees waived.

Outstanding fees

1.8 The Finance Office of a hospital is responsible for the recovery of outstanding fees. When such recovery action is futile, the cases are referred to the Hospital Authority Head Office (HAHO). After reviewing these cases, the HAHO initiates further actions (e.g. pursuing legal proceedings) where appropriate. Figure 2 shows the fees owed by patients as at the end of the past five financial years.

Figure 2

Fees owed by patients
(2002 — 2006)



Source: *HA records*

Note: *The HAHO did not have a separate record for fees owed by patients as at 31 March 2002. The $121 million included other receivables, such as rental income from hospital canteens.*

1.9 Table 1 shows an ageing analysis of fees owed by patients as at 31 March 2006.

Table 1

Ageing analysis of fees owed by patients
(31 March 2006)

Overdue period	Outstanding bills		Amount	
(Number of months)	**(Number)**	**(Percentage)**	**($ million)**	**(Percentage)**
= 3	41,515	53%	67.8	52%
> 3 to 6	15,038	19%	28.7	22%
> 6 to 9	9,823	12%	14.9	11%
> 9 to 12	5,180	7%	7.4	6%
> 12 to 24	4,996	6%	8.4	6%
> 24 to 36	1,226	2%	2.0	2%
> 36	877	1%	1.2	1%
Total	**78,655**	**100%**	**130.4**	**100%**

Source: HA records

Write-off of fees

1.10 Fees that remain unsettled after recovery action by hospitals are written off according to authority delegated by the HA Board (see Appendix A). Table 2 shows the amounts of fees written off in the past five financial years.

Table 2

Fees written off by HA
(2001-02 to 2005-06)

Financial year	Fee income	Fees written off (Note)	
	($ million)	($ million)	(Percentage)
2001-02	774.3	**14.4**	1.9%
2002-03	843.4	**17.6**	2.1%
2003-04	1,212.5	**26.7**	2.2%
2004-05	1,352.7	**51.0**	3.8%
2005-06	1,607.7	**43.9**	2.7%

Source: HA records

Note: Since 2003-04, there has been an increase in the amount written off in relation to fees owed by NEPs. For the three years 2003-04 to 2005-06, 79% of the fees written off related to those owed by NEPs (see Table 18 in para. 4.4).

Audit review

1.11 The Audit Commission (Audit) has recently conducted a review to examine the economy, efficiency and effectiveness of the management of outstanding fees by the HA (Note 3). The review focused on the following areas:

(a) collection of outstanding fees by hospitals (PART 2);

(b) collection of outstanding fees by the HAHO (PART 3);

(c) use of public medical services by NEPs (PART 4); and

(d) measures to minimise need for recovery and write-off of fees (PART 5).

Note 3: *Audit has conducted another value for money audit of the management of medical fee waivers. The audit findings are reported in Chapter 6 of the Director of Audit's Report No. 47.*

Initiatives of the Hospital Authority to improve fee recovery

1.12 Audit notes that both the HAHO and hospitals have taken continuous action to improve the collection of outstanding fees. One major new initiative was the development of a new Patient Billing/Revenue Collection (PBRC) System. The existing PBRC System has been used by the HA since 1993. The enhanced features being developed under the new system would facilitate the fee recovery action. Examples of other initiatives of the HA include issuing bills by hand to patients at hospital wards, issuing interim bills on a more frequent basis, and revising medical fee deposit levels for NEPs and private patients. A summary of the initiatives of the HA to improve fee recovery is at Appendix B.

Overall audit conclusion

1.13 Audit supports the HA efforts to improve the collection of outstanding fees. Nonetheless, Audit has found that there are areas where further improvements can be made. A number of audit recommendations have been made to address the issues.

General response from the Hospital Authority and the Administration

1.14 The **Chief Executive, HA** has said that the HA welcomes the audit recommendations. He has also said that:

(a) the HA, being a responsible public organisation, is committed to continuously improving the management of outstanding medical fees and will consider the implementation of the audit recommendations, taking into account their feasibility and cost-effectiveness; and

(b) in a number of cases, action has already been taken or commenced to address the issues raised.

1.15 The **Secretary for Health, Welfare and Food** notes and agrees with the HA's response.

Acknowledgement

1.16 Audit would like to acknowledge with gratitude the full cooperation of the staff of the HA and the Health, Welfare and Food Bureau (HWFB) during the course of the audit review.

PART 2: COLLECTION OF OUTSTANDING FEES BY HOSPITALS

2.1 This PART examines the measures employed by hospitals in the collection of outstanding fees.

Fees collection procedures

2.2 In the HA, the PBRC System is used for issuing bills, recording revenue and providing management information.

2.3 The HA collects the following three types of fees:

(a) ***In-patient fees.*** In-patient fees refer to fees payable by a patient who is hospitalised. If a patient is an NEP, or seeking medical services as a private patient, he is required to pay a deposit (see Appendix C) before admission to hospital (an EP staying in a public ward is not required to pay a deposit). However, the deposit may be paid after admission if:

(i) the medical treatment is of an emergency nature and the attending doctor or the HCE has certified accordingly; or

(ii) the HCE is personally satisfied with a written guarantee of payment of the likely amount due by the patient.

For long-stay patients, interim medical bills are issued ranging from 2 to 7 days (depending on individual hospital's circumstances) for NEPs and every 14 days for EPs. At the time of discharge from hospital, a patient is given a discharge form. He needs to bring the form to the Shroff Office of the hospital to settle all outstanding fees;

(b) ***Out-patient fees.*** For out-patient service (e.g. attending specialist clinics in a hospital), a patient (EP or NEP) has to pay the fees before medical treatment (Note 4). However, if a patient requires urgent medical treatment and cannot pay the fees, the attending doctor may approve deferment of payment; and

(c) ***Accident and emergency (A & E) fees.*** For A & E service, a patient (EP or NEP) should pay fees before or immediately after medical treatment. In

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Note 4: *For community services (e.g. outreach community nursing service), the fees are billed on a monthly basis.*

emergency situations when a patient has not made any payment up-front, he will be given a payment advice for payment later.

2.4 A range of payment methods are available to patients. Patients can pay their fees by cash, cheques, bank drafts, Easy Pay System (EPS), PPS (i.e. payment by phone or Internet service), Octopus or credit cards. There are drop-in boxes for cheques to facilitate payment. The HA is also exploring other payment methods, for example, via convenience stores and automated teller machines (ATMs).

Recovery of outstanding fees

In-patient fees

2.5 If a patient fails to settle his fees at the time of discharge (see para. 2.3(a)), the Finance Office of a hospital will initiate recovery procedures against him. The recovery procedures include:

(a) issuing a final bill to the patient within 3 days from the date of discharge. The final bill lists out all the outstanding fees (including those fees that were previously written off as bad debts) that the patient owes to the hospital (Note 5);

(b) 21 days after the issue of the final bill (or the reminder — see Note 5), issuing a final notice by registered mail to warn the patient that legal proceedings may be instituted unless the outstanding fee is settled within 21 days;

(c) 21 days after the issue of the final notice, i.e. 45 (i.e. 3 + 21 + 21) days (this was 59 days before mid-June 2006) after the date of discharge of a patient, initiating recovery action by making telephone calls to the patient (Note 6), asking him to pay the outstanding fees and reminding him to apply for a fee waiver if he has financial difficulties; and

(d) forwarding the unsettled case, normally six months upon the issue of the final bill, to the HAHO for further action (i.e. write-off of fees or taking legal action against the patient), unless:

Note 5: *Before mid-June 2006, hospitals used to issue a reminder to the patient 14 days after the issue of the final bill. To streamline the fee recovery procedures, since mid-June 2006 the HA has discontinued issuing reminders. As a result, the time interval between the issue of a final bill and a final notice has been shortened by 14 days.*

Note 6: *Telephone calls may be made to a patient's next of kin. Telephone calls may also be made earlier if the outstanding cases involved large amounts of fees.*

(i) active recovery action is being pursued by the hospital; or

(ii) the case is pending because a fee waiver application is under processing; or

(iii) other payment arrangements (e.g. settlement of fees by instalments) have been made.

Out-patient and A & E fees

2.6 The recovery procedures for outstanding out-patient fees and fees for A & E service are generally the same as those for in-patient fees.

Outstanding fees as at 31 March 2006

2.7 According to the HA, in 2005-06, some 70% of the final bills were settled before the final notices were due for issue. As at 31 March 2006, outstanding fees owed by patients amounted to $130.4 million. A breakdown is shown in Table 3.

Table 3

Outstanding fees (31 March 2006)

Type of fees	EPs ($ million)	NEPs ($ million)	Private patients ($ million)	Total ($ million)
In-patient	28.5	69.3	15.2	113.0 (87%)
Out-patient	8.8	0.2	2.1	11.1 (9%)
A & E	1.7	4.6	–	6.3 (4%)
Total	**39.0**	**74.1**	**17.3**	**130.4 (100%)**

Source: HA records

Audit visits to five hospitals

2.8 Audit visited five major hospitals (hereinafter referred to as Hospitals A to E — Note 7) between December 2005 and April 2006 to ascertain the management of outstanding fees at the hospital level. Audit notes that there is scope for improvement in the following areas:

(a) hospitals' initiatives to improve collection of fees (see paras. 2.9 to 2.11);

(b) recovery of outstanding fees by telephone (see paras. 2.12 to 2.19);

(c) forwarding of unsettled cases to the HAHO (see paras. 2.20 to 2.25); and

(d) arrangement for settlement of fees by instalments (see paras. 2.26 to 2.30).

Hospitals' initiatives to improve collection of fees

2.9 Audit noted that some hospitals had developed their own initiatives to improve the collection of fees. These initiatives (see Appendix D for details) include:

(a) ***Initiative 1.*** Improving the accuracy of patients' records thereby facilitating the tracing of patients to settle their outstanding fees;

(b) ***Initiative 2.*** Issuing medical bills by hand to NEPs at hospital wards;

(c) ***Initiative 3.*** Tracking the condition of NEPs to minimise unnecessary stay and the risk of escalation of fees;

(d) ***Initiative 4.*** Making use of the A & E Registration Office to collect fees from discharged NEPs when the Shroff Office is closed;

(e) ***Initiative 5.*** Centralising the recovery of outstanding fees at a particular hospital within a cluster thereby improving the efficiency of fee collection;

(f) ***Initiative 6.*** Making telephone calls to remind patients to pay outstanding fees when they attend medical appointments at out-patient clinics; and

(g) ***Initiative 7.*** Obtaining the latest telephone numbers of patients from ward nurses for recovering outstanding fees.

Note 7: *As at 31 March 2006, the five major hospitals accounted for 43% of the total outstanding fees owed by patients. They also had relatively more NEPs seeking medical services than other hospitals.*

Audit recommendations

2.10 **Audit notes the hospitals' initiatives to improve the collection of fees. In order to maximise the impact of these good initiatives in the HA, Audit has *recommended* that the Chief Executive, HA should:**

(a) **further encourage hospitals to continue developing initiatives with a view to enhancing the efficiency of collection of fees;**

(b) **evaluate the effectiveness of the hospitals' initiatives, taking into account different scales of operation and circumstances among hospitals; and**

(c) **develop good practice guidelines from the hospitals' initiatives and help promote/disseminate such guidelines among all hospitals.**

Response from the Hospital Authority

2.11 The **Chief Executive, HA** has said that the HA agrees with the audit recommendations. He has also said that:

(a) the HA has always encouraged hospitals to develop initiatives for enhancing debt collection as part of the continuous improvement process. Various channels and forums are in place for hospitals to share good practices and improvement opportunities at both management and working levels; and

(b) the HA will continue to actively evaluate good initiatives identified and promote their implementation among clusters, taking into account individual hospital's situation.

Recovery of outstanding fees by telephone

2.12 As mentioned in paragraph 2.5(c), the Finance Office of a hospital takes up to 45 days (this was 59 days before mid-June 2006) before making the first telephone call to a patient. During audit visits, some hospitals informed Audit that they would make earlier calls to patients if the outstanding cases involved large amounts of fees.

2.13 Audit randomly selected 150 in-patient cases (i.e. 20 EP and 10 NEP cases from each of the five hospitals visited by Audit — Note 8) forwarded to the HAHO in 2005-06 to examine whether:

(a) proper records of telephone calls made to patients were maintained; and

(b) telephone calls were made in a timely manner.

Audit observations

Records of telephone calls

2.14 Audit found that hospitals generally recorded the dates of telephone calls and the details of calls made to patients. However, in 32 (21%) of the 150 cases, the dates of calls were not recorded. Furthermore, in 3 cases, there were no records to show that phone calls had been made at all. Of these 35 (i.e. 32 + 3) cases, some involved considerable amounts of outstanding fees (see Table 4).

Table 4

Cases with incomplete or no records of telephone calls (based on the audit sample of 150 in-patient cases in 2005-06)

Hospital	Dates of calls not recorded		No records of calls	
	Number of cases	Total amount ($)	Number of cases	Total amount ($)
A	–	–	–	–
B	–	–	–	–
C	1	39,600	–	–
D	26	515,550	3	8,200
E	5	334,100	–	–
Total	**32**	**889,250**	**3**	**8,200**

Source: HA records and Audit analysis

Note 8: *Audit's sample was confined to cases of fees owed by in-patients (see Table 3 in para. 2.7).*

2.15 **Audit considers that hospitals should keep proper records (e.g. date, person contacted and result of call) of telephone calls made to patients. This provides follow-up trails and facilitates further recovery action.**

Timeliness of telephone calls

2.16 For the remaining 115 cases with proper records indicating that the hospitals had telephoned the patients, Audit analysed the time interval between the date of discharge of patients and the date of the first telephone call to these patients. On average, it was 97 days. In 49 (43%) of the 115 cases, the hospitals took more than 90 days (i.e. one month after the 59 days – see para. 2.5(c)) to make the first telephone call to the patients (see Table 5).

Table 5

Time interval between date of discharge and date of first telephone call (based on the audit sample of 150 in-patient cases in 2005-06)

	Number of cases						
Time interval (Number of days)	**Hospital A**	**Hospital B**	**Hospital C**	**Hospital D**	**Hospital E**	**Total**	
< 31	6	4	8	–	–	18	
31 to 60	7	5	11	1	–	24	
61 to 90	4	13	7	–	–	24	
91 to 120	3	4	2	–	–	9	}
121 to 150	4	2	–	–	3	9	} 49
151 to 180	3	2	1	–	15	21	}
181 to 560	3	–	–	–	7	10	}
Total	**30**	**30**	**29**	**1**	**25**	**115**	

Source: HA records and Audit analysis

2.17 Audit noted that the HAHO had not issued any guidelines on the time-frame for hospitals to make telephone calls to patients. **A long interval, in some cases as shown in Table 5, may prolong the fee recovery process.** It may also reduce the chances of recovering a fee as a patient's personal circumstances may have changed (e.g. change of telephone number and address). On the other hand, a time interval that is too short might cause nuisance to patients. **It is therefore important for the HAHO to take into account all relevant factors and lay down an appropriate time-frame for all hospitals to follow when making telephone calls for fee recovery.**

Audit recommendations

2.18 **Audit has *recommended* that the Chief Executive, HA should issue guidelines to hospitals on:**

(a) **maintaining proper records of the details of telephone calls made to patients; and**

(b) **the time-frame for hospitals to make telephone calls to patients.**

Response from the Hospital Authority

2.19 The **Chief Executive, HA** has said that the HA agrees that there is room for further improvement in the recording of the details of telephone calls made to patients after discharge. He has also said that:

(a) the HA will incorporate guidelines regarding the specific number of telephone calls to be made within specific time-frame into a circular on debt recovery;

(b) the debt recovery process commences before patients are discharged. For example, during their hospitalisation, interim bills are issued and the patients and their next of kin are reminded to pay before discharge, and private patients and NEPs are required to pay deposits upon admission to hospitals (see para. 2.3(a)); and

(c) after discharge of patients, final notice and warning letters are also issued in addition to making telephone calls (see paras. 2.5(b) and (c), and 3.3(b)).

Forwarding of unsettled cases to Hospital Authority Head Office

2.20 As mentioned in paragraph 2.5(d), unless there are actions underway, hospitals are required to forward unsettled cases, normally six months upon the issue of final bills, to the HAHO for taking legal actions against the patients or write-off. During 2005-06, some

42,000 unsettled cases were forwarded to the HAHO. An audit analysis of the time span for forwarding the unsettled cases to the HAHO is shown in Table 6.

Table 6

Time interval between issuing final bills and forwarding unsettled cases to the HAHO (2005-06)

Time interval (Number of months)	Number of unsettled cases			Total amount of fees ($'000)
= 3	899			3,124
> 3 to 6	5,610			7,026
> 6 to 9	15,318			15,856
> 9 to 12	8,052			9,488
> 12 to 24	11,863		35,598	14,023
> 24 to 36	317	12,228		1,104
> 36	48			220
Total	**42,107**			**50,841**

Source: HA records and Audit analysis

Audit observations

2.21 As shown in Table 6, in 35,598 (85%) of the 42,107 cases, the time span for forwarding unsettled cases to the HAHO was more than six months. In 12,228 (29%) cases, it was more than 12 months.

2.22 According to the staff of the Finance Offices of the five hospitals visited by Audit, the action taken at the hospital level before forwarding unsettled cases to the HAHO was mainly making telephone calls to the patients. It appears that these unsettled cases could have been forwarded earlier to the HAHO for further action.

2.23 **Audit considers that, in some cases, the long time span for hospitals to forward unsettled cases to the HAHO might have delayed further action to be taken by the HAHO against defaulters.**

Audit recommendation

2.24 **Audit has *recommended* that the Chief Executive, HA should take measures to ensure that hospitals forward unsettled cases to the HAHO in a timely manner. These may include, for example, the issue of circulars to hospitals reminding them of the requirement and importance of forwarding the unsettled cases promptly to the HAHO.**

Response from the Hospital Authority

2.25 The **Chief Executive, HA** has said that the HA agrees with the audit recommendation. He has also said that:

(a) the HA will formalise the current instruction on the timing of forwarding unsettled cases to the HAHO and closely monitor the compliance by hospitals; and

(b) longer processing time may be required for situations where the identity status (e.g. NEPs) of patients needs clarification and where there is delay in fee waiver assessment due to patients' delay in submitting applications and providing complete information for financial assessment.

Arrangement for settlement of fees by instalments

2.26 Audit notes that some hospitals allow patients to settle fees by instalments. Of the five hospitals visited by Audit, Hospitals B, C and D have adopted such a practice. Table 7 shows a summary of the approved instalment cases for these three hospitals in 2005-06.

Table 7

Instalment cases in three hospitals visited by Audit (2005-06)

Hospital	EPs		NEPs	
	Number of cases	Total amount of fees ($)	Number of cases	Total amount of fees ($)
B	1	12,000	35	309,350
C	–	–	**110 (Note)**	**1,844,803**
D	3	23,450	82	965,425

Source: HA records

Note: Hospital C introduced the practice of settlement by instalments on 1 September 2005. It only provided Audit with information about the instalment arrangement covering the five-month period 1 September 2005 to 31 January 2006.

Although Hospital C introduced the instalment arrangement only on 1 September 2005, the number of instalment cases it approved up to 31 January 2006 was more than that for one year for Hospital B or Hospital D.

2.27 Audit noted that, as at 31 January 2006, patients had failed to pay the scheduled instalments in 81 (74%) of the 110 instalment cases approved by Hospital C.

Audit observations

2.28 The HAHO has informed Audit that payments by instalment arrangement are only offered to patients in exceptional circumstances. Audit however notes that the HAHO has not laid down guidelines on situations where payments by instalments are allowed, and the assessment procedures to be followed. As a result, some hospitals have not used such arrangement whereas some hospitals have been using it more frequently than others.

Audit recommendation

2.29 **Audit has *recommended* that the Chief Executive, HA should devise and promulgate formal guidelines and assessment procedures for the payment of fees by instalments, taking into account the cost-effectiveness of such arrangement.**

Response from the Hospital Authority

2.30 The **Chief Executive, HA** has said that the HA agrees in principle with the audit recommendation. He has also said that:

(a) the HA considers that payment by instalment arrangement should only be applied in exceptional circumstances. Although partial payment of fees by patients allows flexibility in the recovery process, it entails significant administrative work and, based on past experience, the chance of full recovery is remote; and

(b) the HA will incorporate specific guidelines and assessment procedures into a circular on debt recovery for allowing partial payments under exceptional circumstances, taking into consideration the administrative workload.

PART 3: COLLECTION OF OUTSTANDING FEES BY HOSPITAL AUTHORITY HEAD OFFICE

3.1 This PART examines the measures employed by the HAHO in the collection of outstanding fees.

Actions on unsettled cases

3.2 Hospitals submit periodically (e.g. quarterly or half-yearly) the unsettled cases to the HAHO for further action. In 2005-06, 42,000 unsettled cases were forwarded by hospitals to the HAHO (see para. 2.20).

3.3 After the HAHO has received the unsettled cases from hospitals, it will take the following actions:

For all cases

(a) write off, for accounting purposes, the outstanding fees;

(b) select some defaulters and issue warning letters to them. The warning letter informs the defaulter that legal action will be instituted against him if the outstanding fees are not settled immediately;

For cases with Category I debts (Note 9)

(c) file claims with the Small Claims Tribunal (SCT) against those defaulters who have received the warning letters but refused to pay;

(d) arrange execution by bailiff against those defaulters who still refuse to settle the outstanding fees after the SCT judgment;

Note 9: *The HA has internal guidelines which define the range of outstanding amounts of medical fees that constitutes Category I debts. Outstanding fees exceeding the maximum amount of Category I debt are considered Category II debts. For confidentiality reasons, these amounts are not disclosed in this report.*

For cases with Category II debts (Note 9)

(e) contact those defaulters who have received the warning letters, asking them to settle the outstanding fees;

(f) consider referring the cases to the Legal Department of the HA (LDHA) for advice on possible legal proceedings at the District Court or a higher court; and

(g) institute legal action against the defaulters if necessary.

Write-off of outstanding fees

3.4 When the Finance Offices of hospitals forward the unsettled cases to the HAHO for further action, they are required to report the reasons why the cases cannot be settled. For those cases with Category II debts, the Finance Offices also need to attach a detailed case summary.

3.5 It is the HA's established practice that upon receipt of unsettled cases from hospitals, the HAHO will, for accounting purpose, write off the outstanding fees. However, despite the write-off of fees, recovery actions will still be undertaken. According to the HAHO, such write-off of fees is only a financial accounting adjustment to provide for and reflect bad debts. The HAHO has also informed Audit that patients who have not paid their fees do return to the HA for further healthcare services. This has provided the HA with an opportunity to enforce fee recovery.

Audit observations

3.6 Audit noted that the write-offs had been approved according to the HA's schedule of delegated authority (see Appendix A). However, the recording of write-offs was often made before the approval was obtained. Sometimes, it took up to six months before the actual approval was obtained. The timing of write-off of outstanding fees by the HA in 2005-06 is shown in Table 8.

Table 8

Write-off of outstanding fees by HA
(2005-06)

Month in which write-off was posted to accounting records	Month in which approval for write-off was obtained (Note)
April 2005	July 2005
May 2005	July 2005
June 2005	September 2005
July 2005	July & September 2005
August 2005	September 2005 & February 2006
September 2005	January 2006
October 2005	January 2006
November 2005	January 2006
December 2005	January 2006
January 2006	March 2006
February 2006	March 2006
March 2006	May & June 2006

Source: HA records

Note: The write-offs were approved according to the delegated authority as shown at Appendix A.

3.7 The HAHO informed Audit that the posting of write-offs before obtaining approval was solely for operational efficiency. Furthermore, in order not to overload the HA Board with requests for write-offs, approval from the HA Board was sought annually. **Audit notes the HA's explanations, but considers that unsettled fees should only be written off after an approval has been obtained.**

Audit recommendation

3.8 **Audit has *recommended* that the Chief Executive, HA should issue guidelines to HAHO staff to ensure that unsettled fees are only written off from the accounting records after an approval has been obtained.**

Response from the Hospital Authority

3.9 The **Chief Executive, HA** has said that the HA agrees with the audit recommendation. He has also said that currently, approval for write-offs has been obtained on a regular basis and there are control measures to ensure that all write-offs of medical fees are properly authorised. The HA will revise the workflow to ensure that the posting of write-off of unsettled fees is made after an approval has been obtained.

Issue of warning letters to defaulters

3.10 Each month, the HAHO issues warning letters to a number of defaulters. Basically, these defaulters are selected from those who meet the following two criteria:

(a) the amount owed by a defaulter per case falls into a Category I or Category II debt (see Note 9 to para. 3.3); and

(b) the defaulter has received the final notice from the HA (see para. 2.5(b)).

In addition, the HAHO issues warning letters to some defaulters who do not meet the said criteria.

3.11 Based on Audit's analysis, in 2005-06, of the 42,107 unsettled cases forwarded to the HAHO, 3,900 (9%) cases met the selection criteria for issuing warning letters (see para. 3.10). Of these 3,900 cases, warning letters were issued in 2,156 (55%) cases, involving outstanding fees of $17.9 million (i.e. 14% of the average total outstanding fees of $128.3 million for 2005-06). In addition to the 2,156 cases, warning letters were issued in 355 cases (for recovery of $0.6 million) that did not meet the selection criteria. A total of 2,511 warning letters were, therefore, issued in 2005-06.

Audit observations

Selecting more cases for issue of warning letters

3.12 During the five-year period 2001-02 to 2005-06, on average, 44% of the warning letters issued were received by defaulters, whereas 56% were not received. Table 9 shows the audit analysis.

Table 9

Warning letters received by defaulters
(2001-02 to 2005-06)

Financial year	Warning letters issued by HAHO (a) (Number)	Warning letters not received by defaulters (b) (Number)	Warning letters received by defaulters (c) = (a) - (b) (Number)
2001-02	2,396	1,268	1,128
2002-03	2,474	1,289	1,185
2003-04	2,613	1,847	766
2004-05	2,754	1,559	1,195
2005-06	2,511	1,122	1,389
Total	**12,748** **(100%)**	**7,085** **(56%)**	**5,663** **(44%)**

Source: HA records and Audit analysis

3.13 Audit analysed the payment position of the 5,663 cases in which the warning letters were received by defaulters. Details are shown in Table 10.

Table 10

Settlement of cases in which warning letters were received by defaulters (2001-02 to 2005-06)

Financial year	Cases		Cases settled by defaulters				Postal charges (Note)	Amount of settlement net of postal charges
	(a) (No.)	(b) ($'000)	(c) (No.)	$(d) = \frac{(c)}{(a)} \times 100\%$ (%)	(e) ($'000)	$(f) = \frac{(e)}{(b)} \times 100\%$ (%)	(g) ($'000)	(h) = (e) - (g) ($'000)
2001-02	1,128	2,015	285	25%	354	18%	117	237
2002-03	1,185	2,153	225	19%	286	13%	111	175
2003-04	766	1,646	199	26%	457	28%	115	342
2004-05	1,195	5,588	159	13%	1,260	23%	124	1,136
2005-06	1,389	8,819	169	12%	672	8%	129	543
Overall	**5,663**	**20,221**	**1,037**	**18%**	**3,029**	**15%**	**596**	**2,433 (12% of (b))**

Source: HA records and Audit analysis

Note: These refer to postal charges for the issue of warning letters (including those not received by defaulters).

3.14 Table 10 shows that during the period 2001-02 to 2005-06:

(a) on average, the defaulters settled the outstanding fees in 18% of the cases in which they had received the warning letters. This suggests that some defaulters might not wish to face legal proceedings and chose to pay the fees instead; and

(b) the fees recovered, net of the postal charges of $0.6 million, amounted to $2.4 million. The net recovery rate was 12% (see column (h) in Table 10). It appears worthwhile for the HAHO to issue more warning letters to the defaulters.

3.15 Audit noted that, of the 3,900 cases which met the criteria for issuing warning letters in 2005-06, no warning letters were issued for 1,744 (45%) cases (see para. 3.11). The outstanding fees in respect of these 1,744 cases amounted to $9.7 million. **Based on the findings in paragraphs 3.13 and 3.14, Audit considers it desirable for the HAHO to increase the number of warning letters to be issued.**

Issue of warning letters for cases with less than Category I debts

3.16 In 2005-06, the HA had issued warning letters to 259 defaulters who owed less than Category I debts. Such action helps deter non-payment of fees of smaller amounts. Nevertheless, Audit notes that:

(a) as compared with the large number of cases with less than Category I debts, the number of warning letters issued (i.e. 259) is insignificant;

(b) the cost to the HA for issuing a warning letter is nominal; and

(c) there are patients who have settled their fees after receiving the warning letters (see para. 3.14(a)).

Audit considers it desirable for the HAHO to issue warning letters to more defaulters who owed less than Category I debts.

Inclusion of small sums of fees in the warning letter

3.17 In determining the follow-up actions on outstanding fees, the HAHO does not add up the small amounts owed by individual patients. These small amounts, when added up, may show that a patient owes the HA a Category I debt. **Audit considers that the HAHO needs to take measures to improve its procedures, so that all outstanding fees owed by an individual patient are aggregated for the fee recovery process.**

Audit recommendations

3.18 **Audit has *recommended* that the Chief Executive, HA should:**

(a) **consider increasing the number of warning letters to be issued;**

(b) **to show the HA's determination of recovering outstanding fees of small amounts, consider issuing more warning letters to patients whose amounts owed are less than Category I debts; and**

(c) **take measures to aggregate the total amount of outstanding fees owed by an individual defaulter in the HA's fee recovery action.**

Response from the Hospital Authority

3.19 The **Chief Executive, HA** has said that the HA agrees in principle with the audit recommendations. The HA will conduct trial runs on the proposed measures and will evaluate the results in terms of cost-effectiveness for implementation.

Unsettled cases with Category I debts

3.20 For Category I debt cases, if a patient has received the warning letter but refuses to pay, the HAHO will file a claim with the SCT. If the patient still refuses to pay after the HA has won the case, the HAHO may apply to the SCT for a writ of Fieri Facias to enforce the judgment. The writ of Fieri Facias enables the HAHO to instruct the bailiff to seize the goods and chattels of the debtor to the limit that the value of the seized items will cover the amount of outstanding fees and cost of seizure.

3.21 Audit randomly selected and examined 60 cases filed with the SCT to ascertain whether there is room for improvement in the recovery procedures. As the process of recovery action may take more than a year, these 60 cases were selected from those in 2004-05 and 2005-06. Audit observations are set out in paragraphs 3.22 to 3.25.

Audit observations

Long time taken for filing claims and enforcing judgments

3.22 For the 60 cases, Audit analysed the time interval between the date of receipt of warning letter by the patient and the date of filing a claim with the SCT. The results of the analysis indicated that, on average, it was 270 days. In 16 (27%) of the 60 cases, the HAHO took more than 300 days to file a claim with the SCT. Details of the audit analysis are shown in Table 11.

Table 11

Time span for filing a claim with the SCT
(based on the audit sample of 60 cases)

Time span (Note) **(Number of days)**	**Number of cases**
151 to 200	4 (7%)
201 to 250	18 (30%)
251 to 300	22 (36%)
301 to 350	16 (27%)
Total	**60 (100%)**

Source: HA records and Audit analysis

Note: This counts from the date of receipt of warning letter by the patient to the date of filing a claim with the SCT.

3.23 Audit noted that in 41 (68%) of the 60 cases, despite the fact that the SCT judgments were in favour of the HA, the patients refused to pay and the HA decided to apply for a writ of Fieri Facias to enforce the judgments. Of these 41 cases, there were 24 (59%) cases where a writ of Fieri Facias had been applied at the time of audit in June 2006. The average time span between the date of the SCT judgment and the date of applying for a writ of Fieri Facias for these 24 cases was 149 days. Details are shown in Table 12.

Table 12

Time span between the date of SCT judgment and the date of applying for a writ of Fieri Facias

Time span (Number of days)	Number of cases (Note)
51 to 100	3
101 to 150	9
151 to 200	6
201 to 250	5
251 to 300	1
Total	**24**

Source: HA records and Audit analysis

Note: In the audit sample of 60 cases, there were 24 cases where a writ of Fieri Facias had been applied (up to 30 June 2006).

3.24 **The long time span, as shown in Tables 11 and 12, delays the whole debt recovery process. It may also reduce the chances of recovering the outstanding fees.**

Considering the need to use other enforcement methods

3.25 It is an established practice that after enforcing the judgments, if the outstanding fees still cannot be recovered, the HAHO will close the cases. Audit notes that apart from applying for a writ of Fieri Facias, the HAHO rarely used other methods of debt recovery (Note 10).

Note 10: *Examples of other enforcement methods include the oral examination of judgment debtors before the court, applying to the court for charging orders on the patients' properties, applying to the court for a prohibition order to prohibit the patient from leaving Hong Kong, and instituting bankruptcy proceedings against the patients.*

Audit recommendations

3.26 **Audit has *recommended* that the Chief Executive, HA should:**

(a) **take necessary measures to expedite the filing of claims with the SCT; and**

(b) **in addition to applying for a writ of Fieri Facias, explore the feasibility and cost-effectiveness of using other methods to recover judgment debts.**

Response from the Hospital Authority

3.27 The **Chief Executive, HA** has said that the HA agrees with the audit recommendations. He has also said that measures have been taken to expedite the filing of claims with the SCT. Furthermore, enforcement of judgment by methods other than writ of Fieri Facias will be considered on a case-by-case basis, taking into account the likelihood of success.

Unsettled cases with Category II debts

3.28 For unsettled cases with Category II debts in which the patients have received warning letters but have not paid, the HAHO will contact the patients asking them to settle their fees. The HAHO may also refer the cases to the LDHA for advice on possible legal proceedings at the District Court or a higher court.

3.29 In 2005-06, hospitals submitted 54 cases involving Category II debts to the HAHO for further action. They represented a total of $7.9 million owed by 48 NEPs, 3 EPs and 3 persons using HA medical services as private patients. Of these 54 cases:

(a) warning letters were issued to the defaulters in 18 cases. In 9 such cases, the defaulters had received warning letters and the HAHO had initiated recovery action against them; and

(b) of these 9 cases, 6 cases were not yet settled as at 30 June 2006.

Audit examined the progress of recovery actions for these 6 cases. Audit findings are summarised in paragraphs 3.30 to 3.37.

Audit observations

Follow-up of fee recovery action

3.30 Of the six cases in paragraph 3.29(b), in three cases, the HAHO was making settlement arrangements with the patients. Table 13 shows the progress of the settlement of these three cases as at 30 June 2006.

Table 13

Progress of settlement of three outstanding cases

Case	Type of patient	Amount ($)	Position as at 30 June 2006 (Note)
1	EP	51,748	The patient, who was still staying in hospital, said that he would approach the Medial Social Workers to apply for a waiver of medical fees.
2	NEP	57,700	The patient was discharged in January 2005. The patient made a few partial payments totalled $1,700. The latest payment of $50 was made in February 2006.
3	NEP	584,900	The patient (a new-born baby) was discharged in September 2005. The patient's father said that he had sought assistance from the consulate of his country, but the consulate could not provide assistance. In January 2006, the case was forwarded to the HAHO for further action. In April 2006, the HAHO requested the hospital to write to the consulate to confirm if what the patient's father said was true.

Source: *HA records*

Note: *The HA advised that, as at 30 September 2006:*

Case 1: *the patient was still staying in hospital. His waiver application had been rejected. The HA was arranging the issue of a demand letter to the patient;*

Case 2: *the HA had issued a demand letter to the patient in late August 2006. As there was no response, the HA was considering the issue of a writ of summons to him; and*

Case 3: *the consulate had advised the HA that no financial assistance could be offered. The case was pending approval for write-off.*

3.31 **Audit considers that the HAHO needs to take action to finalise the outstanding cases as soon as possible, particularly for Cases 2 and 3 where the patients were discharged in 2005 but their fees had still not been settled as at the end of June 2006.**

Timeliness of seeking legal advice

3.32 Of the remaining three cases in paragraph 3.30, the HAHO had sought legal advice from the LDHA. These three cases comprised one private patient case and two NEP cases. The total outstanding amount was $310,000. Based on the legal advice, the HAHO issued demand letters to all the three defaulters and conducted land search in the private patient case. The land search indicated that the patient possessed a property. As at 30 June 2006, the HAHO was considering applying to the court for a charging order on the patient's property (Note 11).

3.33 Table 14 shows an audit analysis of the time span for seeking legal advice for these three cases (i.e. the time interval between the date of receipt of the warning letter by the defaulter, and the date on which the HAHO sought advice from the LDHA).

Table 14

Time span for seeking legal advice

Case	Type of patient	Time span (Number of days)
4	Private patient	248
5	NEP	191
6	NEP	170

Source: HA records and Audit analysis

Note 11: *The HA advised that, as at 30 September 2006, in the private patient case, the HA was taking action to apply for a charging order. Of the two NEP cases, in one case, the HA had not taken further action as the patient's husband was a CSSA recipient. The case was closed. In the other case, the HA had issued a demand letter and a writ of summons to the patient in September 2006.*

3.34 Table 14 shows that the long time interval ranged from 170 to 248 days. The HAHO needs to consider setting a time-frame within which legal advice has to be sought.

Increasing the amount of deposits to cover hospital fees

3.35 People using medical services as private patients are required to pay standard rates of deposits depending on the class of hospital ward, category of operation and hospital type (see Appendix C). However, the HCE can demand a higher amount of deposit on a case-by-case basis.

3.36 Of the nine cases where the patients had received warning letters (see para. 3.29(a)), there were two private patient cases. In both cases, the patient paid a standard deposit of $100,000 for a major operation (see Appendix C). The amounts of the final bills of these two cases had both exceeded the deposits paid. In one case, the patient paid the debt after receipt of the warning letter. In the other case (i.e. the private patient case mentioned in para. 3.32), the patient did not settle the debt.

3.37 **Audit considers that the HCEs of individual hospitals need to estimate the hospital fees of private patient cases and demand higher amounts of deposits, if it is envisaged that the standard amounts of deposits are insufficient to cover the estimated hospital fees. This would minimise the need for recovery action and the write-off of bad debts.**

Audit recommendations

3.38 **Audit has *recommended* that the Chief Executive, HA should:**

(a) **take early action to finalise those cases where arrangements had been made with the patients to settle the outstanding fees;**

(b) **consider setting a time-frame within which legal advice should be sought, if the unsettled cases cannot be satisfactorily dealt with by the HAHO; and**

(c) **remind the HCEs to demand, if necessary, a higher amount of deposit from private patients in order to cover the estimated hospital fees.**

Response from the Hospital Authority

3.39 The **Chief Executive, HA** has said that the HA agrees with the audit recommendations. He has also said that:

(a) actions have been taken for the cases identified including legal action in some of those cases;

(b) the HA will incorporate a time-frame for seeking legal advice on unsettled cases into a circular on debt recovery and remind its staff to adhere to the time-frame. It should be noted that the time required to finalise cases depends on factors such as the complexity of situations, whether NEPs are involved and the cost implications when legal actions are to be taken at higher level of courts;

(c) currently, different tiers of deposits have been established to cater for the cost of different categories of operations. These standard deposit rates are adopted for ordinary cases while hospital management is given the authority to increase the deposit rate on a case-by-case basis based on the estimated fees (see para. 3.35). The HA will remind hospitals of this arrangement and the mechanism in place; and

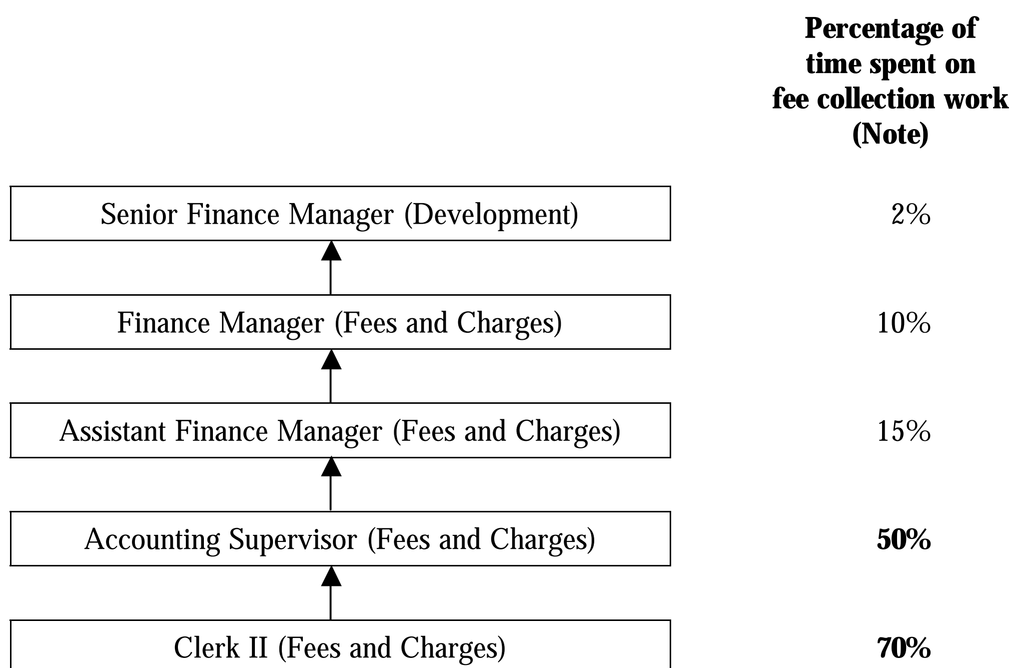
(d) medical bills are often issued shortly after major operations to recover fees from patients on a timely basis.

Manpower requirement of collection team

3.40 According to the HAHO's calculation, the cost (staff cost plus on-cost) of the fee collection work at the HAHO level is $590,000 a year. Figure 3 shows the extent of involvement of members of the HAHO collection team.

Figure 3

Involvement of the HAHO collection team in fee collection work (30 June 2006)



Source: *HA records*

Note: *The time spent is computed on the basis of working hours.*

Audit observations

3.41 As can be seen from Figure 3, at the HAHO level, only two staff (i.e. the Accounting Supervisor and Clerk II) are more actively involved in collection of outstanding fees, spending about 50% to 70% of their time. They have to deal with a large number of unsettled cases (42,000 in 2005-06 – see para. 3.2) including undertaking all sorts of recovery actions which are often laborious and time-consuming. **In Audit's view, the HA needs to review the manpower requirement of the HAHO collection team.**

Audit recommendation

3.42 **Audit has *recommended* that the Chief Executive, HA should review the manpower requirement of the HAHO collection team, taking into account its workload and the need to maximise operational efficiency.**

Response from the Hospital Authority

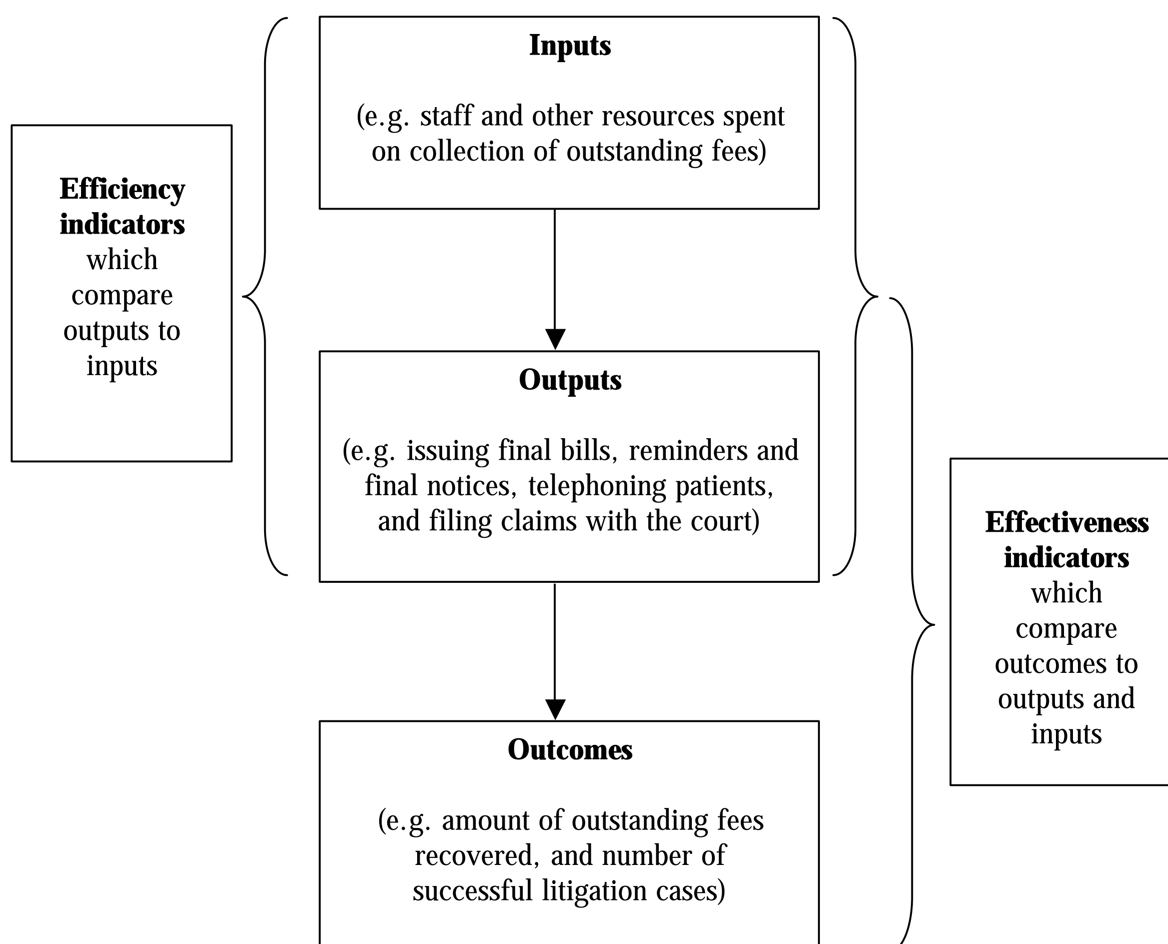
3.43 The **Chief Executive, HA** has said that the HA agrees with the audit recommendation and will review the manpower requirement as a continuous process, taking into account cost-effectiveness, workload and operational efficiency.

Performance management

3.44 Performance management provides a means to measure how well an organisation has performed. In developing performance management, an organisation should aim to report the efficiency and effectiveness of its activities. Efficiency indicators relate the resources (i.e. inputs) used by an organisation to its outputs. Effectiveness indicators relate an organisation's inputs and outputs to the outcomes of its activities. Figure 4 shows the performance indicators for the collection of outstanding fees.

Figure 4

Performance indicators for the HA's collection of outstanding fees



Source: Audit research

Audit observations

3.45 Audit notes that, apart from the ageing analysis of medical fees receivable (which is not exactly a performance indicator) published in the Annual Report of the HA (Note 12), the HAHO has not published other performance indicators on the collection of outstanding fees. **For better public accountability and transparency, Audit considers that the HAHO needs to consider developing and publishing more performance indicators relating to the efficiency and effectiveness of the HA's fee collection work.** Examples of efficiency and effectiveness indicators that the HAHO may adopt are shown in Table 15.

Table 15

Examples of efficiency and effectiveness indicators for HA's collection of outstanding fees

Efficiency indicators • Average cost for handling each unsettled case • Average time taken for handling each unsettled case • Number of unsettled cases handled per staff per month
Effectiveness indicators • Fee recovery rate (i.e. amount of settled fees as a percentage of the total amount of outstanding fees) • Successful litigation rate (i.e. number of successful litigation cases as a percentage of the total number of unsettled cases litigated)

Source: Audit research

Note 12: *In addition, internally, hospitals have to furnish quarterly returns on their bad debt ratios (i.e. amount of cases written off as a percentage of the total amount of fees) to the HAHO for management control purposes.*

Audit recommendations

3.46 **Audit has *recommended* that the Chief Executive, HA should:**

(a) **identify and develop more efficiency and effectiveness indicators to assess the performance of the HA's collection of outstanding fees;**

(b) **set targets for the performance indicators developed; and**

(c) **publish the result against the performance indicators and targets set.**

Response from the Hospital Authority

3.47 The **Chief Executive, HA** has said that the HA agrees with the audit recommendations and will consider developing more performance indicators in addition to the existing indicators.

PART 4: USE OF PUBLIC MEDICAL SERVICES BY NON-ELIGIBLE PERSONS

4.1 This PART examines the adequacy of measures to address the increasing use of public medical services by NEPs.

Increasing use by non-eligible persons

4.2 Over the past few years, there has been a substantial increase in the number of NEPs using in-patient services of hospitals. The total number of cases involving NEPs who used the HA services increased by 22% from 60,322 in 2003-04 to 73,434 in 2005-06, as shown in Table 16. The majority of these patients are visitors from the Mainland. These patients are predominantly female and many of them use obstetric service.

Table 16

Use of public medical services by NEPs (2003-04 to 2005-06)

Financial year	Number of in-patient cases			Number of out-patient and A & E cases	Total number of cases
	Obstetric service (a)	Other services (b)	Total (c) = (a) + (b)	(d)	(e) = (c) + (d)
2003-04	**9,657**	**4,108**	**13,765**	46,557	60,322
2004-05	**13,063**	**4,393**	**17,456**	53,908	71,364
2005-06	**14,460**	**6,385**	**20,845**	52,589	73,434
Total	**37,180**	**14,886**	**52,066**	**153,054**	**205,120**

Source: HA records

Fees owed by non-eligible persons

4.3 According to the HA records, during the financial years 2003-04 to 2005-06, the average settlement rate of fees owed by NEPs was 77%. The amount of fees owed by them was significant. Table 17 shows the amounts of fees owed by HA patients as at the end of the past three financial years. On average, fees owed by NEPs accounted for 55% of the total amount of fees owed by HA patients.

Table 17

Fees owed by HA patients
(2004 — 2006)

Financial year ended	Fees owed by			Total
	EPs ($ million)	NEPs ($ million)	Private patients ($ million)	($ million)
31.3.2004	45.8	**80.3**	9.1	135.2
31.3.2005	48.5	**61.3**	16.3	126.1
31.3.2006	39.0	**74.1**	17.3	130.4
Total	**133.3 (34%)**	**215.7 (55%)**	**42.7 (11%)**	**391.7 (100%)**

Source: HA records

Write-off of outstanding fees

4.4 The amount of bad debts relating to NEPs was also high. During the period 2003-04 to 2005-06, of the $121.6 million of fees written off by the HAHO, $95.8 million (79%) related to fees owed by NEPs. Details are shown in Table 18.

Table 18

Fees written off by the HAHO
(2003-04 to 2005-06)

Financial year	Fees written off			Total
	EPs ($ million)	NEPs ($ million)	Private patients ($ million)	($ million)
2003-04	5.7	**19.6**	1.4	26.7
2004-05	8.5	**40.9**	1.6	51.0
2005-06	7.9	**35.3**	0.7	43.9
Total	**22.1 (18%)**	**95.8 (79%)**	**3.7 (3%)**	**121.6 (100%)**

Source: HA records

Remedial measures

4.5 The increasing use of public medical services by NEPs has put heavy pressure on the frontline staff of hospitals. It has also caused a significant increase in bad debts. The HWFB and the HA have therefore considered possible measures to address the problem. In considering the measures, the guiding principle is that the government subsidy should be targeted at benefiting local residents only.

4.6 An array of measures have been proposed and deliberated by the Legislative Council Panel on Health Services (hereinafter referred to as the Panel). However, most of the measures have not yet been taken further as they were considered ineffective to address the problems, difficult to implement, or having legal implications. Only the two measures mentioned in paragraphs 4.7 and 4.8 have been adopted for implementation.

Obstetric package fee for NEPs

4.7 Since 1 September 2005, with the support of the Panel, the HA has implemented a package fee of $20,000 (Note 13) for NEPs using obstetric service (obstetric package). The obstetric package covers delivery and maintenance fees in a public ward for the first three days of hospitalisation. The objective of the package is to deter the use of public medical services by NEPs and to discourage premature discharge of patients against medical advice. To ensure that the objective of the package could be met, the HA would carry out a review after six months of its implementation, including a review of the level of charge for the package.

Action against NEPs who owed fees

4.8 In June 2005, the HWFB reported to the Panel that it was exploring the viability of amending the law so that a visitor who had yet to settle his fees with the HA can be prevented from re-entering Hong Kong. In January 2006, it was decided that the HWFB would complete the drafting instructions for the necessary legislative amendments for reporting to the Panel before June 2006.

Audit observations

4.9 The HA conducted a review of the obstetric package in late June 2006 and found that the obstetric package is effective in rectifying some of the problems identified, but needs modifications to further address the problems. **Audit considers that the HA needs to continue to monitor closely the effectiveness of the obstetric package, and modify it where appropriate.**

4.10 Since January 2006, the HWFB has re-considered the proposed measure of preventing NEP defaulters from re-entering Hong Kong, but a decision was not yet reached as to whether it should be implemented by legislation or through administrative means. **Audit considers that the HWFB needs to decide on the option to be adopted and report to the Panel accordingly.**

Note 13: *The package fee of $20,000 was calculated on the basis of average in-patient cost of obstetric service, which covered the full cost of the relevant staff, operation, procedures and consumables.*

Audit recommendations

4.11 **Audit has *recommended* that the Chief Executive, HA should continue to monitor closely the effectiveness of the obstetric package, and modify it where appropriate.**

4.12 **Audit has *recommended* that the Secretary for Health, Welfare and Food should:**

(a) **expedite the review of the implementation of the proposed measure to deal with NEPs who have not yet paid their fees; and**

(b) **report the decision on the proposed measure to the Legislative Council Panel on Health Services.**

Response from the Hospital Authority

4.13 Regarding the audit recommendation in paragraph 4.11, the **Chief Executive, HA** has said that the HA evaluated the effectiveness of the NEP obstetric package in June 2006 and that revisions to the obstetric package will be considered where necessary.

Response from the Administration

4.14 The **Secretary for Health, Welfare and Food** accepts the audit recommendations in paragraph 4.12. He has said that the draft framework to deal with NEP defaulters is being finalised.

Encouraging non-eligible persons to purchase travel insurance

4.15 As mentioned in paragraph 3.29, in 2005-06, of the 54 unsettled cases with Category II debts submitted to the HAHO for further action, 48 (89%) cases related to NEPs. Of these 48 cases, at least 6 (13% — Note 14) involved NEPs from the Mainland who had accidents during their stay in Hong Kong.

Note 14: *In 29 of the 48 cases, Audit could not ascertain from the HA records the reasons for the admission of the Mainland visitors to hospitals.*

Audit observations

4.16 **Audit considers that, for the benefits of Mainland visitors, and to minimise the incidence of bad debts arising from hospitalisation, the HWFB needs to promote the idea that they should have travel insurance (to cover medical expenses) during their stay in Hong Kong.**

Audit recommendation

4.17 **Audit has *recommended* that the Secretary for Health, Welfare and Food should, in consultation with the Commissioner for Tourism, consider taking measures to promote the idea that Mainland visitors should have travel insurance for their visit to Hong Kong.**

Response from the Administration

4.18 The **Secretary for Health, Welfare and Food** accepts the audit recommendation.

PART 5: MEASURES TO MINIMISE NEED FOR RECOVERY AND WRITE-OFF OF FEES

5.1 This PART examines the measures that may be used to minimise the need for fee recovery action and write-off of fees.

Preventive versus corrective measures

5.2 In PARTs 2 to 4, Audit has made recommendations that aim to improve the fee collection practices of the HA. These recommendations are mainly of a corrective nature. Fee recovery action, which is often time-consuming and could be costly, will still be necessary. In this PART, Audit examines some preventive measures that may be used to minimise the need for fee recovery action and the write-off of fees.

Frequent defaulters

5.3 There are some patients who frequently do not pay their fees after using public medical services. An analysis of the defaulted payment of fees is shown in Table 19.

Table 19

Defaulted payment of fees for the five years ended 31 August 2006

Number of cases in default	Number of patients (a)	Amount of fees in default			Average amount of fees in default per patient (e)= (d) ÷ (a) ($)
		Written off in the five years (b) ($'000)	Outstanding as at 31 August 2006 (c) ($'000)	Total (d)= (b)+(c) ($'000)	
EPs					
1 to 2	136,289	20,080	46,671	66,751	490
3 to 5	19,211	6,586	12,653	19,239	1,001
6 to 10	3,884	2,842	4,696	7,538	1,941
11 to 15	846	1,022	1,567	2,589	3,060
16 to 20	305	360	699	1,059	3,472
> 20	**340**	659	1,031	1,690	4,971
All EPs	**160,875**	31,549	67,317	**98,866**	615
NEPs					
1 to 2	35,360	104,464	80,152	184,616	5,221
3 to 5	1,118	14,213	16,437	30,650	27,415
6 to 10	115	1,758	2,047	3,805	33,087
11 to 15	17	482	973	1,455	85,588
16 to 20	4	1,608	27	1,635	408,750
> 20	**10**	437	392	829	82,900
All NEPs	**36,624**	122,962	100,028	**222,990**	6,089
All EPs and NEPs	**197,499**	**154,511**	**167,345**	**321,856**	**1,630**

Source: HA records and Audit analysis

5.4 As shown in Table 19, for the five years ended 31 August 2006, about 161,000 EPs and 37,000 NEPs had defaulted on payment of fees, amounting to $99 million and $223 million respectively. Some of these patients had frequently defaulted on payments. For example, there were 340 EPs and 10 NEPs, each of whom had defaulted on payment of fees in more than 20 cases.

Audit observations

5.5 It is the government policy that no one will be denied adequate medical care due to lack of means (see para. 1.6). To fulfil this policy, it is an established practice that the HA provides public medical services to patients irrespective of whether they have previously defaulted on payment of fees.

5.6 Under the existing public healthcare system, those patients who default on payment of fees can apply for fee waivers if they have financial difficulties (see para. 1.6). In practice, when hospital staff telephone them for the settlement of their outstanding fees, they are also advised that they can apply for fee waiver (see para. 2.5(c)). Furthermore, Medical Social Workers pay visits to wards to assist patients in making the fee waiver applications.

5.7 Those patients included in Table 19 had either not applied for fee waivers, or had applied but their applications were rejected as they were unable to meet the criteria for granting waivers. **Audit considers that, in view of the large amount of fees involved, the HAHO needs to devise effective measures to deal with frequent defaulters.**

5.8 **Audit notes that, at present, hospitals do not have adequate measures to help identify frequent defaulters. The lack of adequate measures makes it difficult for the HA to take any effective action.** The present situation is described below:

(a) ***In-patients.*** The Admission Office of a hospital does not have a system to help identify whether a patient has owed the HA any outstanding fees when he is being admitted to the hospital (Note 15); and

Note 15: *A hospital may use the Frequent Defaulters Report (produced by the PBRC System) to identify fees owed by patients under hospitalisation. However, as this report is generated on a weekly basis only, it cannot provide the hospital with the up-to-date position on fees owed by patients.*

(b) ***Out-patients.*** The Out-patient Registration Office of a hospital has a computerised system to help the registration staff identify whether a patient has any outstanding fees at the time when he attends an out-patient appointment. However, the information provided by the system is limited only to **the same hospital.** Furthermore, because the system does not have a function to support the collection of outstanding fees, the staff at the Out-patient Registration Office will ask the patient to pay the outstanding fees at the Shroff Office of the hospital. If the patient does not pay the fees, he will still be able to obtain out-patient service.

In Audit's view, the HA needs to further enhance its information system in order to provide complete and up-to-date data on defaulters and the fees they owe, and to support the collection of outstanding fees from frequent defaulters.

Audit recommendations

5.9 **Audit has *recommended* that the Chief Executive, HA should:**

(a) **further enhance the HA system to help identify defaulters when they attend medical treatments or are admitted to hospitals; and**

(b) **consider devising cost-effective measures, at an early date, to pursue settlement of outstanding fees from frequent defaulters.**

Response from the Hospital Authority

5.10 The **Chief Executive, HA** has said that the HA agrees with the audit recommendations. He has also said that:

(a) the HA has a system to monitor defaulted payments and will continue to enhance the system. Additional measures are being devised to promptly identify the frequent defaulters for debt recovery actions on a timely basis, such as showing outstanding fees on the receipts and appointment slips for out-patient attendance (see item (II)(f) of Appendix B); and

(b) of the outstanding fees of $167 million of receivables for medical bills as at 31 August 2006 (see Table 19 in para. 5.3), over 50% of them had been overdue for less than three months.

Surcharge on overdue fees

5.11 Unlike some government departments (e.g. the Rating and Valuation Department and the Water Supplies Department), the HA does not impose a surcharge on overdue fees. In February 2006, the Financial Policy Group (FPG — Note 16) of the HA considered imposing a surcharge on overdue fees. However, up to the end of June 2006, no further progress was made.

Audit observations

5.12 Imposing a surcharge on overdue fees, if implemented, could prompt patients to settle their fees punctually and reduce the need for further recovery action. Audit also notes that there is no surcharge on fee settlement by instalments. **Audit considers that the HAHO needs to give priority to finalising its review, including imposing a surcharge on fee settlement by instalments.**

Audit recommendation

5.13 **Audit has *recommended* that the Chief Executive, HA should, in consultation with the Secretary for Health, Welfare and Food, expedite the HA review of the imposition of a surcharge on overdue medical fees, including imposing a surcharge on fee settlement by instalments.**

Response from the Hospital Authority

5.14 The **Chief Executive, HA** has said that the HA will consult the Secretary for Health, Welfare and Food on the feasibility of imposing a surcharge on overdue medical fees.

Incorrect addresses

5.15 During Audit's visits to hospitals, hospital staff informed Audit that incorrect addresses had prevented medical bills from being delivered, resulting in write-off of medical fees. An audit analysis of the hospitals' reasons for forwarding 42,000 unsettled cases to the HAHO for follow-up (see para. 3.2) indicates that 7,736 (18%) cases had incorrect addresses provided by patients.

Note 16: *Members of the FPG include the Chief Executive, HA and Cluster Chief Executives of all the seven clusters of hospitals and institutions. The FPG, which holds meeting every two months, reviews and decides on major financial and related policy issues and the development of strategic approaches/programmes for the HA.*

5.16 These 7,736 cases involved an outstanding amount of medical fees of $9.3 million (i.e. 18% of the total outstanding amount). Audit noted that the HA was aware of the importance of maintaining correct patients' addresses, and had taken various measures to improve their accuracy. Details are shown at Appendix E.

Audit observations

5.17 While noting the HA's initiatives to improve the accuracy of address records of patients, Audit is concerned about the large amount of outstanding medical fees being written off due to incorrect addresses.

HA initiative to provide an alert indicator on incorrect addresses

5.18 The HA had considered a suggestion that the computer system of the In-patient Admission Office of a hospital should provide an indicator to alert the hospital staff about incorrect addresses previously provided by patients (see Measure 1 of Appendix E). The suggestion was adopted by the HA's Continuous Quality Improvement Group. System enhancement for this initiative is scheduled for completion by late 2006. According to the HA, the "incorrect address" indicator will be interfaced to the systems of both the In-patient Admission Offices and the Out-patient Registration Offices. Audit notes the latest development and supports the HA's initiative which will help improve the accuracy of patients' addresses, as well as avoid the sending of medical bills repeatedly to the same wrong address.

Hospitals' practices to meet the address proof requirements

5.19 The HA had worked on other initiatives on the issue of address proof. Examples include the requirement to submit a proof of address and the distribution of notices on such requirement to patients (see Measures 2 and 3 of Appendix E). Audit noted that hospitals had also posted notices of address proof requirements in the Shroff Office and patient registration offices. A summary showing the practices of the seven clusters to meet the address proof requirements is given at Appendix F.

5.20 Among the seven clusters, there were different practices in meeting the address proof requirements. Furthermore, while some clusters had instituted some address proof requirements, the majority of the clusters had not requested patients to provide address proof upon registration for medical services (see Appendix F). **Audit considers that the HAHO needs to standardise hospitals' practices by establishing a set of address proof requirements for use by hospitals.**

Strengthening the verification of address records

5.21 In February 2006, the FPG decided to improve the accuracy of addresses through strengthening the verification of address records during registration (see Measure 4 of Appendix E). As at the end of June 2006, there were no detailed plans on how the verification could be implemented. **Audit considers that the HA needs to work out the details as soon as possible to ensure that the patients' addresses are accurate.**

Audit recommendations

5.22 **Audit has *recommended* that the Chief Executive, HA should**:

(a) **standardise hospitals' practices on address proof requirements by establishing a comprehensive set of guidelines for hospitals to follow;**

(b) **ensure that hospitals follow the address proof guidelines established**; **and**

(c) **work out how the verification of address records is to be implemented.**

Response from the Hospital Authority

5.23 The **Chief Executive, HA** has said that the HA agrees in principle with the audit recommendations. He has also said that the HA acknowledges the usefulness of obtaining address proof from patients. Measures will be devised and incorporated into a circular on debt recovery to improve the accuracy of patients' addresses. Practices among hospitals will be standardised as far as possible. However, the address proof requirement may not be applicable to certain patient groups, such as the elderly, who may genuinely not be able to provide address proof.

Appendix A
(paras. 1.10 and 3.6 refer)

The Hospital Authority:
schedule of delegated authority for write-off of outstanding fees
(30 June 2006)

	Fees to be written off	**Delegated authority**
(a)	**For cases not involving fraud or negligence or important point of principle:**	
	Up to $50,000 per case	Director (Finance) or above or Hospital Governing Committee
	Up to $250,000 per case	Director (Finance) or above
	Up to $1 million per case	Chief Executive, HA
(b)	**For cases due to theft or suspected theft:**	
	Up to $10,000 per case	Director (Finance) or above or Hospital Governing Committee
	Up to $50,000 per case	Director (Finance) or above
	Up to $500,000 per case	Chief Executive, HA
(c)	**For cases involving fraud, negligence, important point of principle or cases other than (a) and (b) above**	The HA Board

Source: HA records

Appendix B
(paras. 1.12 and 5.10(a) refer)

Initiatives of the Hospital Authority to improve fee recovery (2003-04 to 2006-07)

(I) Improvement initiatives implemented

(a) creating a patient billing data repository;

(b) issuing of interim bills to NEPs;

(c) accepting payments by Renminbi pay card;

(d) revising medical fee deposit levels for NEPs and private patients;

(e) allowing the payment of fees by Octopus;

(f) enhancing the computer systems to facilitate frontline staff to remind patients to pay overdue fees;

(g) enhancing the PBRC System to record more details of fee recovery actions taken;

(h) discontinuing the sending of payment reminders to patients;

(i) reporting of potential problematic cases to the HAHO by hospitals;

(j) issuing bills by hand to patients at hospital wards;

(k) sharing fees and charges information among HA staff in the HA Intranet;

(l) providing checklists on fee recovery actions by hospitals on unsettled cases; and

(m) developing system to remind registration staff to update patient information.

Appendix B
(Cont'd)
(paras. 1.12 and 5.10(a) refer)

(II) Improvement initiatives being implemented

(a) implementing a new PBRC System;

(b) enhancing the computer systems to draw frontline staff's attention to inaccurate addresses reported by patients;

(c) installing self-service fee collection kiosks at hospitals;

(d) allowing payment of fees via convenience stores and ATMs;

(e) providing training in fee recovery skills for staff; and

(f) enhancing system to show outstanding fees on the receipts and appointment slips of Out-patient Clinics.

(III) Improvement initiatives being studied for feasibility

(a) outsourcing debt collection services;

(b) imposing surcharge on overdue fees;

(c) reviewing the opening hours of Shroff Offices and exploring other alternative payment methods;

(d) addressing jointly with the Government issues arising from increasing use of public medical services by Mainland visitors;

(e) enhancing the computer system to facilitate the updating of patient status;

(f) printing bills in wards upon discharge of patients;

(g) allowing payments in advance for patients who frequently use the HA services;

(h) enhancing the accuracy of patients' records (e.g. address); and

(i) introducing fees and charges posters and notices in simplified Chinese.

Source: HA records

Appendix C
(paras. 2.3(a), 3.35 and 3.36 refer)

Deposits for hospital medical services
(30 June 2006)

Hospital medical services	**Amount of deposit** ($)
(a) Private wards (applicable to EPs and NEPs using medical services as private patients)	
Acute hospitals	
First class ward and category of operations	
(i) No operations / minor / intermediate	60,000
(ii) Major / ultra-major	100,000
Second class ward and category of operations	
(i) No operations / minor / intermediate	40,000
(ii) Major / ultra-major	100,000
Other hospitals	
First class ward	50,000
Second class ward	33,000
(b) Public wards (applicable to NEPs only)	
General hospitals (acute and other hospitals)	33,000
Psychiatric hospitals	7,200

Source: HA records

Appendix D
(para. 2.9 refers)

Hospitals' initiatives to help improve the efficiency of fee collection

Initiative 1: Improving the accuracy of patients' records

Before a patient is admitted to hospital for medical treatment, he should register at the Admission Office. For emergency cases, a patient should register at the A & E Registration Office. For a new patient or a patient whose personal information has been changed, the Admission/Registration Office will require the patient to verbally provide his personal details, while at the same time inputting such details into the computer.

In Hospital E, the Admission/Registration Office requires patients to provide their personal information by completing a registration form first. Based on the form, the Admission/Registration Office inputs the information into the computer. According to Hospital E, this has improved the accuracy of the patients' records and has, as a result, facilitated the hospital to trace the patients to settle their outstanding fees.

Initiative 2: Issuing medical bills to NEPs by hand at hospital wards

As fees payable by NEPs are usually of large amount, the Finance Offices of hospitals generally give priority to collecting fees from NEPs. In Hospitals B and D, the Finance Offices would contact the ward staff to find out in advance when NEPs would be discharged, so that they could issue by hand the medical bills to these patients, and at the same time attempt to collect fees from them before they are discharged.

Initiative 3: Tracking the condition of NEPs

In order to avoid outstanding fees from escalating, the Finance Office of Hospital C sends weekly memos to doctors requesting them to certify that the NEPs under their attention are still in emergency status and continuous care is needed. In the memos, the doctors are also informed of the amounts of deposits and fees owed by these NEPs.

Initiative 4: Assisting the Shroff Office to collect fees

When a Shroff Office is closed, fees cannot be collected from patients. In Hospital C, there is an arrangement to enable the A & E Registration Office (which operates 24 hours daily) to collect fees from discharged NEPs after the closing of the Shroff Office. The arrangement is only applicable to NEPs because the hospital has to ensure that the registration service is not affected, and that no additional staff resources are required.

Initiative 5: Centralising the recovery of outstanding fees

Individual hospitals within a cluster are generally responsible for all sorts of work that relate to revenue collection, such as issuing bills, collecting fees and taking fee recovery action. In the cluster to which Hospital C belongs, fee recovery action is performed centrally at Hospital C. Audit enquiries with responsible staff in Hospital C indicated that such a centralised arrangement had helped improve the efficiency of fee collection and utilisation of staff resources. It had also strengthened internal controls through a greater degree of segregation of duties.

Initiative 6: Making telephone calls to patients with outstanding fees who have arranged for new out-patient medical appointments

In Hospital B, Finance Office staff regularly sorts out a list of patients with outstanding fees who have new medical appointments at out-patient clinics. The staff make telephone calls to these patients to remind them to pay, when they come for medical appointments, the fees that they owe to the hospital.

Initiative 7: Obtaining telephone numbers of patients from ward nurses

In order to contact discharged in-patients for follow-up medical treatment, ward nurses usually require patients to provide them with updated contact telephone numbers. In Hospital E, to help follow up the patients with outstanding fees, the Finance Office contacts the ward nurses to enquire about any new telephone numbers of these patients where necessary.

Source: HA records and Audit enquiries

Appendix E
(paras. 5.16, 5.18, 5.19 and 5.21 refer)

Measures to improve the accuracy of patients' addresses

Measure 1: Creating an alert indicator against problematic addresses in the computer system

In October 2004, at a meeting held by the Fees and Charges Sharing Group of the HA (Note), members were concerned that medical bills were sometimes sent to the same wrong address of a patient repeatedly. They suggested that an indicator should be added to the computer system of the In-patient Admission Office of a hospital to indicate those problematic addresses where medical bills had been sent but were returned due to non-delivery. When a patient attended medical service next time, the Admission Office could identify the patient and ask him to provide the correct address.

Measure 2: Distributing notices to patients on the need to provide address proof

In June 2005, to improve the accuracy of the addresses of patients, the HAHO encouraged hospitals to distribute notices to patients informing them of the need to present a proof of address (e.g. electricity or telephone bill) for every registration for medical service.

Measure 3: Requirement to submit address proof upon registration/admission or before discharge of patients

In October 2005, some FPG members suggested that patients should be requested to provide address proof upon registration/admission or before discharge.

Measure 4: Strengthening the verification of address records during registration

In February 2006, the FPG decided to improve the accuracy of addresses through strengthening the verification of address records during registration.

Measure 5: Completing a registration form before admission to hospitals

Hospital E has taken measures to improve the accuracy of patients' records, including their addresses, by requiring patients to complete a registration form before admitting to hospital for medical treatment. The personal information so obtained is kept in a computer system (see Initiative 1 at Appendix D).

Source: HA records

Note: Members of the Fees and Charges Sharing Group comprise the finance representatives (e.g. Finance Managers) of seven clusters and the HAHO.

Appendix F
(paras. 5.19 and 5.20 refer)

Different practices of the seven clusters of HA hospitals to meet the address proof requirements (30 June 2006)

Cluster	**Notice of address proof requirements posted in Shroff Office and patient registration offices (Note)**	**Notice of address proof requirements distributed to patients in Shroff Office and patient registration offices (Note)**	**Patients requested by hospital staff to provide address proof**
Hong Kong East Cluster	Yes	No	No
Hong Kong West Cluster	Yes	No	Only at the Admission Office
Kowloon East Cluster	Yes	No	No
Kowloon Central Cluster	Yes	Reminder to bring address proof was shown on the medical appointment slip issued only by Specialist Out-patient Clinics	Only at the Specialist Out-patient Clinics and in the case of new patients
Kowloon West Cluster	Yes	The notice was given to each patient during registration in some hospitals of the cluster	No
New Territories East Cluster	Yes	No	No
New Territories West Cluster	Yes	No	No

Source: HA records and Audit analysis

Note: These include In-patient Admission Office, Out-patient Clinic Registration Office and A & E Registration Office.

Appendix G

Acronyms and abbreviations

A & E	Accident and emergency
ATMs	Automated teller machines
Audit	Audit Commission
CSSA	Comprehensive Social Security Assistance
EP	Eligible person
EPS	Easy Pay System
FPG	Financial Policy Group
HA	Hospital Authority
HAHO	Hospital Authority Head Office
HCE	Hospital Chief Executive
HWFB	Health, Welfare and Food Bureau
LDHA	Legal Department of the Hospital Authority
NEP	Non-eligible person
PBRC System	Patient Billing/Revenue Collection System
SCT	Small Claims Tribunal