Public Healthcare Financing and Provision in Hong Kong: A Public-Private Partnership Approach

by

CHAN Sze Yan, Rosanna (3035135189)

CHU Dik Lun, Ernest (3030135062)

LAU Chung Hang, Kevin (1999422019)

WONG Ka Shun (1998006313)

WU Wai Hung, Samuel (2008961248)

Capstone Project Report submitted in partial fulfillment of the requirements of the Master of Public Administration

Department of Politics and Public Administration

The University of Hong Kong

July 2016

Declaration

We hereby declare that this Capstone Project Report, entitled "Public Healthcare Financing and Provision in Hong Kong: A Public-Private Partnership Approach", represents our own work, except where due acknowledgement is made, and that it has not been previously included in a thesis, dissertation or report submitted to this University or any other institution for a degree, diploma or other qualification.

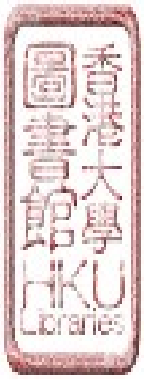
CHAN Sze Yan, Rosanna (3035135189) Signature:

CHU Dik Lun, Ernest (3030135062) Signature:

LAU Chung Hang, Kevin (1999422019) Signature:

WONG Ka Shun (1998006313) Signature:

WU Wai Hung, Samuel (2008961248) Signature:



Acknowledgements

We would like to begin with expressing our thanks and gratitude to Professor Ian Thynne, our supervisor of this capstone project, for his assistance, support and wise counsel. Without his guidance and feedback, we would not have been able to complete this project and we are indebted to him for his contribution to our work. In addition, we would like to thank the faculty members of the HKU Master of Public Administration programme for teaching and imparting knowledge and wisdom to us over the past two years. Last but certainly not least; we would like to thank our family and friends – in particular, our parents, spouses and children. We are thankful for their unfailing support, their love and care, all of which has helped us to complete this project.

Abstract

The dual track healthcare system by which the public and private sectors complement each other has served Hong Kong over the years. The public sector is the main provider of healthcare services to the public, accounting for 88% in-patient services and 30% out-patient services, while the private sector offers the remaining. Hong Kong is now facing pressing challenges, including ageing population and the rising of medical expenses. The medical investments and expenses have increased vigorously by 60% in seven years to $52 billion in 2014-15. Currently, public hospitals are overburdened, and the queue and waiting time for public healthcare services are very long.

Several consultancy reports especially the Rainbow Document and the consecutive Harvard Reports in 1997 and 1999 have identified limitations of financing and provision of healthcare services in Hong Kong, and concluded the healthcare system was not sustainable. They suggested the needs for further exploration and development of different financing and provisions of healthcare services. The Government then introduced public private partnerships - collaborations between the public and private sector, aiming to enhance the sustainability of the healthcare system by recalibrating t balance between the public and private sector.

The project addresses the public healthcare financing and provision in Hong Kong, with

emphasis on the public private partnership (PPP). By studying the different theories and natures relating to concepts namely Goods and Services, Financing and Provision and PPP of healthcare industry, an analytical framework is formulated to investigate the development of healthcare system in Hong Kong as well as the delivery of public healthcare services through different types of PPP to evaluate the effectiveness of PPP as a government tool to enhance the provision of public healthcare services. Five real cases of PPP in Hong Kong are examined against the framework and evaluated through eight criteria including effectiveness, user satisfaction, efficiency, equity, transparency, public/private involvement, government and private sector relationships and monitoring on service provision. Recommendations on further development of PPP are proposed based on the concluding observations of local PPP cases and overseas experience.

List of Figures and Tables

Table 1	Types of Goods and Services	15
Table 2	Categorization of Financing and Provision of Healthcare Goods and Services	27
Table 3	Total Expenditure as percentage of GDP	49
Figure 1	Hong Kong Health System Development in Past Decades	51
Figure 2	Distribution of sources of financing for public and private healthcare in Hong Kong	54
Figure 3	Milestone of PPP development in Hong Kong, 1990-2012	58
Table 4	Waiting time for cataract surgery in public hospitals (as of 31 March 2008)	73
Table 5	Waiting time for cataract surgery in public hospitals (as of 31 March 2016)	77
Table 6	The distribution by districts of the enrolled Medical Practitioners (EMPs) and enrolled Chinese Medicine Practitioners (ECMPs) (August 2014)	89
Table 7	Participation of RCHs and DCCs for the pilot project (as at end-February 2014)	104

Content

Declaration i

Acknowledgements ii

Abstract iii

List of Figures and Tables v

Chapter 1 Introduction 1

Chapter 2 Analytical framework 12

Introduction 12

Goods and Services 13

Basic characteristics 13
Factors affecting accessibility 16
Factors affecting continuous availability 23

Financing and Provision Strategies 26

Main components 26
Public financing and provision 28
Private financing and provision 29
Hybrid financing and provision 31

The Emergence of Public Private Partnerships 33

Basic theories 33
Characteristics of PPP 34
The reasons for entering into PPP 36
Relations between partners and other stakeholders 36

Evaluation of PPPs as Hybrid Financing and Provision Arrangements 36

Evaluation criteria 36
Effectiveness 37
Efficiency 38
Due process: equity, transparency and public/stakeholders' involvement 39
Regulatory framework and flexibility 40
Collaborative relationships 41

Synthesis of Analytical Framework 45

Chapter 3 Hong Kong's Healthcare System and Policies 48

Introduction 48

Healthcare Goods and Services 50

Financing and Provision Strategies 53

Types of Public Private Partnership 56

Evaluation of Hong Kong Healthcare System 58

Concluding Comments 62

Chapter 4 Case Study of Public Private Partnership 63

Introduction 63

Gleneagles Hong Kong Hospital (GHKH) 65

Background 65
Goods & services: accessibility and availability 66
Financing & provision strategies 66
Type of public private partnership 68
Evaluation of public private partnership 68
Overall observations 71

Cataract Surgeries Programme (CSP) 72

Background 72
Goods and services: accessibility and availability 72
Financing & provision strategies 73
Type of public private partnership 74
Evaluation of public private partnership 75
Concluding Observations 79

Tung Wah Group of Hospitals (TWGH) .....

Background .....
Goods and Services .....
Financing & Provision Strategies .....
Type of Public Private Partnership .....
Evaluation of Public Private Partnership .....
Overall observations .....

Elderly Health Care Voucher Scheme (HCVS) 86
Background 86
Goods & services: accessibility and availability 87
Financing & provision strategies 89
Types of public private partnership 89
Evaluation of public private partnership 90
Overall observations 95
Pilot Project on Outreach Primary Dental Care Services for the Elderly in Residential Care Homes and Day Care Centres 96
Background 96
Goods & services: accessibility and availability 98
Financing & provision strategies 98
Type of public private partnership 99
Evaluation of public private partnership 101
Overall observations 106
Concluding Comments 107
Chapter 5 Lessons, Recommendations and Conclusion 109
Introduction 109
The Key Lessons Learnt 110
Analysis in relation to PPP theories 111
Recommendations 112
Increase the proportion of using PPP for public healthcare services under concession 113
Bring in more experts for contract design 114
Formulate complete guidelines setting up PPP contract 116
Monitoring of private partners 117
Conclusions 118
References 1

Chapter 1 Introduction

Focus and Objectives of the Project

The project addresses the public healthcare financing and provision in Hong Kong, focusing on the public private partnership (PPP), one specific type of financing and provision strategies. It aims to study the nature and delivery of public healthcare services through different types of PPP to evaluate the effectiveness of PPP as a government tool to tackle the current challenges in public healthcare sector. By examining and evaluating the real cases of PPP in Hong Kong based on eight dimensions, some recommendations on the further development of PPP in public healthcare sector in Hong Kong are proposed.

Why the Healthcare Sector and the PPP Approach were Chosen for Study

The public and private healthcare sectors have been complementary to each other under the dual-track healthcare system operating in Hong Kong for long. The public sector predominantly provides secondary and tertiary healthcare services, accounting for 88% in-patient services while the private sector gives choices to those who can afford to pay for personalised healthcare services with better amenities. There has been a consensus in general on the need of reform of healthca sector to recalibrate the public and private ratio to maintain the long-term sustainability of t healthcare system due to a number of forcing reasons. The reasons include ageing populatic

rising medical costs and greater public expectation on the quality of healthcare services. Hong Kong, like other parts of the world, is facing the challenges of an ageing population. According to the Hong Kong Population Projections 2015-2064, by 2029, elders aged 65 or above will reach 2 million, and there will be more than 1 in 4 persons (26%) aged 65 or over (Census and Statistics Department, 2015). It is expected that in about 15 years, 33% of the total population, meaning 1 in 3 persons will be elders in Hong Kong by 2064. Currently, the public hospitals have already been overstretched, and the queue and waiting time for specialist outpatient clinic services and inpatient services of public hospital, and the accident and emergency (A&E) etc. are long. The ageing population will further put heavy burden on healthcare services, resulting in more lengthy waiting time and lists for services. Also, the rising medical cost leads to increasing healthcare expenditure. The public health expenditure soared by 60% from 32 billion in 2007/8 to 52 billion in 2014/15 (Food and Health Bureau, 2014d). However, the resources of the Government are limited. Therefore, it is critical to build a sustainable healthcare system to meet all coming challenges. Though a number of public consultations on healthcare reform had been conducted since 1990s, the public opinion on the different reform options to readjust the balance has been varied.

PPP have been employed considerably by different countries in the provision of public servic including healthcare services. The private sector brings in their expertise, skills, innovation a cost effectiveness etc. during the collaboration. The international experience shows PPP may

able to bring various advantages to the community, the public and private sectors, including service quality enhancement, efficiency, innovation, creativity, better utilisation / saving resources, sharing risks and responsibilities, creating more jobs etc. (Torchia, Calabrò, & Morner, 2015). Hong Kong has been attracting private sector investment to deliver public services like some major infrastructure facilities such as the cross-harbour and other tunnels (Efficiency Unit, 2008). In the healthcare sector, the 1997 and 1999 Harvard report consecutively pointed out the need to greater integrate the public and private sector to develop outpatient services to reduce the waiting time, and to improve and further public-private partnerships in Hong Kong (Gould, 2001). The Government then issued an introductory guide to PPP in 2003 and its second edition in 2008. More PPP projects in healthcare sector involving public and private collaborations like Cataract Surgeries Programme (CSP), Elderly Health Care Voucher Scheme (HCVS) and Outreach Primary Dental Care Services for the Elderly in Residential Care Homes and Day Care Centres have launched since then. The consultation paper on Voluntary Healthcare Insurance Scheme (VHIS) released earlier provoked vigorous public discussions.

Reform on healthcare system to maintain its sustainability is of utmost importance to meet the future challenges. Therefore, it is worth investigating into the healthcare sector from a Pl approach to evaluate if PPP would bring the said various benefits to healthcare system in Ho Kong. Could PPP help alleviate the pressure of the public healthcare system effectively? Wh

kinds of PPP could bring more advantages given the context of healthcare system in Hong Kong? What elements make a PPP successful? The project is thus studying the healthcare sector and PPP, aiming to propose some recommendations in the way forward about the development of PPP in the healthcare sector, so as to enhance the sustainability of healthcare system.

Research Questions and Propositions: Theory and Practice

With a view to investigating the development direction and the types of PPP that suit the context of the healthcare system in Hong Kong and enhance its sustainability, the project examines interrelated aspects of healthcare in terms of goods and services, financing and provision strategies, and PPP and their characteristics and types, leading to their evaluation. The research questions are as follows:

1. What are the distinctive features of healthcare goods and services, with particular reference to issues of accessibility and availability?
2. What healthcare financing and provision strategies are available to governments, including issues of risk, flexibility and transaction costs related to public private partnerships (PPP)?
3. What are the criteria for evaluating PPP, including factors critical for successful and effective PPP?
4. What healthcare financing and provision strategies, including PPP, have been used in Ho Kong – and how successful and effective have they been?

Healthcare services possess the characteristics of possibility to restrict someone's access to it and availability for subsequent consumption or use. The delivery arrangement of healthcare services is therefore subject to accessibility and availability in which could be hindered by various barriers. Maintaining adequate accessibility and availability to healthcare services are important in a sense to meet ever growing and changing public healthcare needs due to different challenges like an ageing population.

There are different financing and provision strategies available to governments. Financing/funding and provision/delivery of healthcare services can be categorised in terms of sources of resources allocations, namely public, private or both (hybrid). Different financing and provision strategies, formulated by the different combinations of these three modes, are available to cater for various societal needs by governments. Among the different strategies, PPP with their different types due to the various level of involvement of public and private partner incur different level of risks, flexibility and transaction costs. Therefore, it is necessary to evaluate different types of PPP to assess their effectiveness to suit the needs of various societies and enhance the provision of healthcare services. Evaluation criteria include effectiveness, user satisfaction, efficien equity, transparency, public/private involvement, government and private sector relationships a monitoring on service provision. Regulatory framework, the flexibility allowed in the framewo

public/private involvement and collaborative relations are identified to be critical factors for successful PPP.

In Hong Kong, public financing and provision, and PPP mode including public financing and private provision, hybrid financing and provision have been used, with an increasing tendency of using the latter two strategies to enhance the sustainability of healthcare system. In general, different types of PPP including concession and contracting out are generally successful to enhance the provision of health services.

Overview of Analytical Framework

In any public system, different types of goods and services are to be rendered by the government. According to Ostrom and Ostrom (1991), goods and services can be classified based on their nature in two dimensions: excludability and jointness of use. Thynne and Peters (2015) further developed the dimensions and termed them as accessibility and availability of a good and service, resulting four different types of goods and services. Healthcare services in Hong Kong are toll goods. The delivery arrangement of healthcare services is subject to accessibility and availability, factors affecting accessibility and continuous availability are thus examined.

Two components of healthcare system, financing/funding and provisions/delivery, can

categorised into public, private and hybrid (Parliament of Canada, 2001; Asian Development Bank, 2016). These dimensions are arrayed to form a financing and service provision matrix, creating different types of financing and service provision strategies like public financing with private provision; public financing with hybrid provision; private financing with public provision etc. PPP then emerges as some specific types of financing and provision strategies which is the focus of the study.

PPP involves the collaborations between the public and private sector to achieve goals in healthcare sector, delivering quality services to the public and ensuring adequate access to the products and services they needed. The characteristics of PPP including establishing a transparent regulatory framework, contractual flexibility, risk and transaction cost involved are examined. One important element of PPP is the relations between partners and other stakeholders. Balanced power relations, trust building and stakeholders' involvement are found to be critical for partnership development. There are different types of PPP like concession, contractual arrangement and public finance initiative.

Like any government interventions, it is necessary to evaluate these specific types of financing a provision strategies. References are drawn to the approach for evaluating public policy by Vedu (2006), other theories of evaluation of public interventions (Baldwin, Cave, & Lodge, 201

Salamon, 2002) and the characteristics of partnerships. The eight criteria used to evaluate PPP are effectiveness, user satisfaction, efficiency, equity, transparency, public/stakeholder involvement, government and private sector relationship, and monitoring on provision of service.

The analytical framework provides a lens through which the history and development of the healthcare policy of Hong Kong over the years in Chapter 3 and five real cases of PPP in Hong Kong in Chapter 4 are examined and analysed. Based on the analysis and evaluation of real cases of PPP, some recommendations are proposed for the further development of PPP to facilitate the sustainability of the healthcare system in Hong Kong.

Research Methodology

In the project, different concepts in the healthcare industry namely goods and services, financing and provision, PPP and evaluation, and their interrelationships are studied. Review of different literatures, journals, articles of scholars and theories of public administration is essential to develop the analytical framework. The concept of PPP, which is comparatively new, requires an extensive study of literatures and reviews to attain a more comprehensive understanding of its types and characteristics.

Desktop research is mainly employed throughout the research project. The development a

history of healthcare system and policies, together with the five real cases of PPP examined in the project are government policies, so empirical data are drawn from official websites of relevant government bureaux, departments and Hospital Authority (HA), consultation documents, press releases, annual reports of HA and relevant partnering organisations like Tung Wah Group of Hospitals (TWGH), government survey reports and law information etc. As the government policies are vigorously discussed in Legislative Council (Legco) meetings, so efforts have been made in reviewing all relevant Legco discussion papers and meeting minutes to obtain a more comprehensive picture.

The five cases with their provision of services are being assessed from different perspectives to obtain insights in enhancing the delivery of services, so the research is largely qualitative. Different perspectives like user satisfaction, relations between partners and other stakeholders, public / stakeholders' involvement are included in the analysis. Therefore, empirical data are collected from newspaper articles, reviews, journals, surveys by professional bodies and the government replies to LegCo questions so as to grasp the various latest opinions, views and comments from public, academics, industry, Legislative Councilors and other stakeholders for the sake of thorough analysis. Audit Commission reports also provides objective and comprehensi information about the performance and operation of the cases.

To analyse the history and development of the healthcare policy of Hong Kong, references have been particularly drawn to consultancy reports like the Scott Report, the Rainbow Document and the Harvard Report, and the consolidated reviews from the medical journals and research paper on these reports. Supplemented by the comparison against the international benchmark standards or ranking data on media reports, a more holistic picture of the development and performance of the local healthcare policies in the past few decades is thus obtained.

A study on overseas experience on PPP, the Private Finance Initiative (PFI) in United Kingdom (UK) is included in Chapter 5 to draw possible insights and propose recommendations for further development of PPP in Hong Kong. Relevant journals, UK Government website, articles by UK medical professional association and UK media reports have been used as reference to acquire thorough and latest understandings about UK experience.

The above desktop research method offers an efficient channel without cost implications and privacy concerns incurred by interviews to acquire comprehensive and up-to-date information. Also, diverse views from different stakeholders and public can be collected for conducting critical and objective analysis and evaluation on the local and overseas PPP cases leading to recommendatio in the way forward.

Chapter Outline

The project comprises five chapters, including this Introduction. Chapter 2 establishes the analytical framework for the project based on a literature review of interrelated aspects of healthcare system and PPP, namely goods and services, financing and provision strategies, and PPP and itscharacteristics and types, leading into their evaluation. Chapter 3 outlines and analyses the history and development of the healthcare policy of Hong Kong over the years, including the substantial development and revolutionary reform. The analysis on the empirical data and its interrelated components are made against the analytical framework set out in Chapter 2, that is goods and services, with particular focus to issues of accessibility and availability; financing and provision strategies; PPP and its characteristics and types; and leading to their evaluation. Chapter 4 examines and analyses five real cases of PPP in Hong Kong using the eight evaluation criteria devised in Chapter 2, namely, effectiveness, user satisfaction, efficiency, equity, transparency, public/stakeholders' involvement, government and private sector relationship, and monitoring on provision of service with some concluding observations and comments. Chapter 5 concludes the paper by first studying the overseas experience on PPP, the UK Private Finance Initiatives (PFI), as a reference for the local PPP study. The insights and lessons learnt in both local and overseas experience are deliberated with the reference to theories of PPP. Recommendations are th proposed to facilitate further development and effectiveness of PPP in local contexts.

Chapter 2 Analytical framework

Introduction

In any governmental system, there would be a range of goods and services rendered by government or its agencies. Some goods and services provided are regarded as fulfilling indispensable basic needs whilst some exist to facilitate the betterment of the government and the society. Nevertheless, fundamentally, all goods and services should be equally allocated and everyone should have equal access opportunity.

As such, responsible and capable governments adopt different financial strategies and different delivery mechanisms for goods and services of every type. Financing and delivery mechanism are two independent dimensions which can be arrayed in relation to one another leading to various partnership combinations in different sectors. Each combination has merits and demerits for the implementation and continuous operation. Therefore, with a view to selecting the most appropriate combination, there would be different evaluative challenges.

In this study, public healthcare services, always regarded as basic welfare as well as human well being, is selected in which the public-private partnership approach is specifically chosen to evaluated. Indeed, PPP have become a common approach to address healthcare proble worldwide aiming to improve the quality of healthcare services and efficiency of service delive

PPP can take a variety of forms depending on the degree of participation and responsibility of public and private sectors. There are successful cases showing the benefits of PPP of enhancing effectiveness and efficiency of healthcare services by leveraging the strengths of both sectors – the resources, management skills, expertise and technology of private sectors, and produce innovative strategies etc. (Torchia, Calabrò & Morner, 2015). They are regarded as effective and cost efficient. However, evidence demonstrating PPP's performance and efficiency is still weak, for example, Hellowell and Pollock (2009) criticised the PFI funding of capital investment for being highly problematic. So can PPP truly achieve the goals and bring benefits as it is designed for? To what extent can PPP improve the quality and efficiency of healthcare services to the public? What constitutes or what factors lead to a valuable and effective PPP?

Goods and Services

Basic characteristics

In the delivery of public services, one should focus on the analysis of the problems and then determine the suitability of different delivery arrangement. Such delivery arrangement is also known as public service configuration. Public service configuration is a selection or organization of provision and production at the collective level. Provision is making a particular good service available. And production aggregates of technical factors to yield goods and servic meeting the requirement, in other words, it is transforming inputs into outputs (Davis & Ostro

1991). By matching a suitable configuration, public services could be delivered even under limited resources of the society and distinct capability of the government. One of the most important factors affecting the design consideration is the nature of goods and services.

Goods and services, at the focus of provision and financing activities, can be classified according to their nature as public, private, toll and common pool. One classification is the well-established Ostrom and Ostrom (1991) which distinguished goods and services according to two criteria, i.e. excludability and jointness of use or consumption. Excludability is the ability to deny a potential user from using and consuming a good or service while jointness of use is whether the consumption or use by one person would preclude another person to consume or use.

Thynne and Peters (2015) further developed the two criteria and used the terms accessibility and available of a good and service instead. The accessibility characteristic can be arrayed into two classes, i.e. very difficult, if not impossible, to restrict someone's access to it and possible to restrict someone's access to it. Availability can also be arrayed into two classes, i.e. available or unavailable for subsequent consumption or use by someone else. By arraying the characteristic in a matrix, the four types of good and services are revealed as indicated in Table 1.

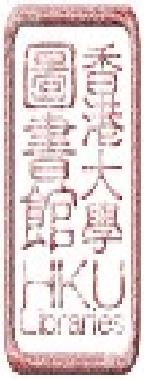


Table 1 : Types of Goods and Services

Accessibility of the good or service	Availability of the good or service once access is gained and consumption or use occurs	
	Available for subsequent consumption or use by someone else	Unavailable for subsequent consumption or use by someone else
Very difficult, if not impossible, to restrict someone's access to it	Public good or service	Common pool good or service
Possible to restrict someone's access to it	Toll good or service	Private good or service

Source: Thynne and Peters (2015)

Healthcare services in Hong Kong, generally possess the characteristics of possible to restrict someone's access to it and available for subsequent consumption or use, is a toll good. Indeed, healthcare services in Hong Kong are charged with a price for access. And the services are available for subsequent consumption because once provided, one person's consumption of these services does not affect another person's consumption.

Meanwhile, accident & emergency (A&E) services and emergency ambulance services are public goods. They are not restricted for someone to access to it because, once provided, every citizen is entitled to consume the services during emergency. It is inhumane to exclude or preve consumption of these services by those who choose not to pay for it. These services are al available for subsequent consumption because once provided, one person's consumption of the emergency services does not affect another person's consumption.

Factors affecting accessibility

In broad sense, access is frequently adopted in the sense of property and it is virtually the ability to derive benefits from things including material objects, persons, institutions, and symbols. In fact, generally speaking, it refers to a wider range of social relationships that can constrain or enable people to gain benefits from resources.

The core objective of enabling access to the healthcare services is not only to avoid death or severely diseases of citizens, but also to achieve arrays of possible health outcomes of the administration. Unfortunately, it is not always easy or possible for the administration so that the public can enjoy sufficient access to the healthcare services. Access has many dimensions related to healthcare services provision, including physical location, information, financial, cultural and structural, etc. In many situations, access will be hindered and limited by various factors, including inadequate personal insurance coverage, transportation and language barriers. In a wider sense, barriers to access will lead to possible inequitable situation to the vulnerable groups like elderly, poor and certain ethnic minorities.

When making the access to the resources open and available, the administration needs to spend a input significant resources so as to maintain adequate access. Capital and social identity determi who has the resource access priority. With technology, markets, knowledge, authority and soc

relations can certain enhance or influence access. In this regard, social policies, markets, capital, authority, technologies, knowledge, and even social identities have close relationship with access (Ribot & Peluso, 2003)

Access to capital is clearly a factor shaping who is able to benefit from resources (Blaikie, 1985; Shipton & Goheen, 1992). Wealth or capital affects other types of access since wealth, social identity of the status and power where those people have privilege to have access to production and exchange, opportunities, forms of knowledge, authority. Access to knowledge is critical in shaping who can benefit from resources (Foucault,1978).

Access is often mediated by social identity, membership or group in the community, including groupings by age, gender, ethnicity, religion, status, profession, place of birth, common education, or other attributes that constitute social identity (Bullard, 1990; Shipton & Goheen, 1992; Peluso & Vandergeest, 2001).

To be a micro-perspective for access to healthcare services, should there be barriers to access to the healthcare services, healthcare needs can be not met, resulting in delays in receiving care and inabili to obtain preventive services and hospitalizations. A lot of people failed to receive medical servic because of economic barriers, transportation difficulties, racial or ethnic discrimination,

unavailable services.

When it comes to access to healthcare services, over the years, there has been quite a wide range of relevant definitions focusing on various aspects. For instance, the ability to reach, afford, and obtain entrance to services (Parker, 1974); the ability of a population or a segment of the population to obtain health services (Khan & Bhardwarj, 1994); the provision of the right service, at the right time, in the right place (Rogers, Flowers, & Pencheon, 1999); the availability of an adequate supply of healthcare services and the individual's opportunity to obtain healthcare when it is wanted or needed (Gulliford et al., 2002) and considered in terms of four key aspects: availability, utilization, relevance and effectiveness, and equity (Chapman et al., 2002).

While retrieving reliable statistics in relation to healthcare outcome is in fact difficult, the causation between a barrier to access and an outcome may be complex and hard to be proved. Having said that, the relationship between access barriers and outcome measures is still intuitive and important, making access barriers an important consideration upon deciding the public policy on healthcare.

In the society nowadays, there are a lot of factors, either directly or indirectly, affecting access healthcare services, namely physical location, information, finance, cultural and structural issu Some of the factors, interestingly, could be overcome by administrative measures, otherwise, some

them could not be. According to the RUPRI (2014), the factors affecting access to healthcare can be divided into 3 categories, namely (1) structural, (2) financial, and (3) personal/cultural. Structural affects access to medical care directly in association with the number, type, concentration, location, or organizational configuration of healthcare providers. Financial affects access relating to the ability of patients to pay for needed medical services or willingness of medical practitioners and hospitals as to how to treat patients. Personal and cultural factors may affect patients in need of medical attention to seek for medical care. The presence or absence of a single barrier does not make one being certainly access to the medical services.

As mentioned, structural factors affect access to healthcare services in a number of ways, including number, type, location, and configuration of healthcare services providers. The evident examples of limiting access are related to the supply side, including insufficient hospitals or medical clinics, lack of medical professionals, long waiting time (RUPRI, 2014). Additionally, long distances to travel to medical centers or hospitals and undeveloped transportation network would also hinder the accessibility. The above case with limited access is easily found in developing countries with insufficient government funding and in remote areas. The limited number of hospitals and remote location of hospitals undoubtedly impede access to healthcare services. Access is impeded as peop needs to travel a long way to the hospital and needs to spend an undue waiting time for seeki medical care.

The structural factors, nonetheless, could be overcome given the intervention and capital inputs of the state government. With the injection of capital and better planning of the administration, more hospitals could be set up in remote areas to facilitate people living nearby seeking medical assistance more easily or the transportation network to access to the nearby hospitals could be improved. Likewise, more medical practitioners could be employed thanks to the greater input of financial resources from the government.

With a view to providing accessible and more even distributed healthcare services, the structural factors affecting access should be improved and overcome. As a matter of fact, medical practitioners only intend to set up their clinics where the area is accessible so that revenues could be generated. Without improving the accessibility of the rural areas, private medical practitioners have less incentive to set up their business in those areas. That is why many patients rely on the healthcare services provided by the public hospital's outpatient unit or emergency unit. In particular, emergency care does not provide follow up treatment or examination for patients where its effectiveness is worse than regular medical clinics.

With reference to RUPRI (2014), financial factors affecting access to healthcare services are relat to the cost of medical care when the patients use the healthcare services, including payment

medical fees and insurance premium. It is also referred to the financial capacities of the patients to meet the medical expenses.

With the on-going inflation, the costs of healthcare services have been increasing rapidly over the years and such growth is disproportional to the increase in income level. In the absence of medical insurance, most people are unable to afford the medical bills after suffering from serious illness or after surgery in the private hospitals.

For those common operations like Angioplasty or ACL reconstruction, the whole medical bills in private hospitals in Hong Kong range from HK$50,000 to $80,000. Such an amount without medical insurance could not be easily met even by the middle class. Financial factors affecting access to healthcare services in insurance are demonstrated by eligibility for insurance, benefit coverage, and reimbursement ratio.

In term of payment of insurance premium, the problem could be arguably overcome where access to healthcare services would be enhanced. The government could provide tax allowance for those who purchase insurance policy so as to alleviate their spending through tax payment. Of course, t initiative will be in dispute as one may argue that the policy of providing tax allowance for insuran policy holder somehow use public money to subsidise the private market or insurance compani

An optimal level of tax allowance may help in facilitating the initiative by encouraging people from engaging in private medical markets and at the same time alleviating the pressure of public hospitals, hence fostering the access in long run.

Apart from private insurance, public healthcare services are served as a safety net in the community. Financial barrier in accessing public healthcare services therefore brings about adverse impact to the society. The financial factors, fortunately, in accessing public healthcare services could be directly overcome through government subsidy in providing public healthcare. It either could be a direct subsidy in medical expenses or indirect monetary subsidy to those vulnerable groups e.g. elderly or minor by way of health vouchers and fees waiver. Thanks to the government subsidy in whatever form, accessibility to healthcare would be fostered so that most people would be protected by the public provision of healthcare services.

Social identity may affect access to healthcare provision ranging from age, gender, ethnics, races, education, language, religion, profession and any attributes relating to the social identity (Bullard, 1990; Shipton & Goheen, 1992; Peluso & Vandergeest, 2001). The barriers may arise when the patients belonging to a certain ethnic minority speaking a foreign language where it would difficult for them to gain access to the necessary healthcare in a timely and efficient manner. T problems are somewhat not uncommon towards those uneducated, asylum seekers, import

workers, new immigrants, poor people and homeless. At this juncture, the attitude of the healthcare services providers is also of importance whether or not there are administrative measures or policies to assist those in need of medical care.

The barrier problem owing to personal and cultural factors, again, shall be overcome to foster accessibility for the aforementioned people. The healthcare services provider possibly needs to provide interpreters, social workers or medical practitioners with specific training. The government and NGOs should play a role in facilitating these needy to access healthcare services readily. Back to the case in Hong Kong, non-Cantonese or non-English should be an apparent structural barrier when accessing to healthcare services where assistance rendered from the government and the hospital is deemed necessary.

Factors affecting continuous availability

Continuous availability / provision of goods and services becomes another important issue that the government is required to handle in the context of healthcare services, through devising health care policy and other relevant policies in infrastructure and transportation system, etc. Good or service is being continuously available when consumption by one person does not preclude it from the use consumption by another person. That said, consumption of which is not subtractable. In fa

availability of services is affected by a range of factors in the supply side including the number of hospitals, capacity of in-patient or out-patient services and number of medicals officers,

The demand for healthcare services has always been on steady growth and could not be suppressed or controlled, in particular the community with increasing ageing population like Hong Kong. With a view to maintaining continuous availability, the authorities should allocate more resources and capital in provision of healthcare services, including setting up new hospitals as well as recruitment of more medical officers and nurses. Given the limited resources and funding of the government, one has to, fundamentally, provide / control provision of goods and services from the supply-side efficiently and effectively. For public healthcare services, efficiency criteria of supply-side could be enhanced by minimising the capital cost and operation cost of public facilities. In other words, effective use of public budget or financing is one of the possible ways to ensure continuous availability of public healthcare services no matter the services is in a free-entry and fee-for-service market. Indeed, maximizing benefit of the general public is the main objective of public sector.

Apart from the public healthcare sector, the private healthcare sector bears a different objective generation of revenue and profit to an optimal level. Private healthcare services providers tre provision of healthcare services as business and intend to maximise the profit. Neverthele

efficiency criteria of supply-side could be increased by maximizing the profit. Healthcare services in private sector could then be available continuously when the profitability of business could be maintained.

As mentioned, for the purpose of addressing the issue of limited resources and funding of the government for providing healthcare services, the resources must be utilised effectively and efficiently. In this regard, the government is willing to procure services from the private sector to solve the problem on insufficient service provision. When the private sector has the capacity and willing to collaborate provided a business case exists, collaborations between the public and private in different mode starts to begin.

The financing and provision strategy of healthcare service provision is subject to the availability of services. Depending on the availability and demand, different financing and provision strategies are to be formulated to cope with different scenarios under a limited resources setting. From our study, financing and provision of healthcare services are mainly steered by different parties, i.e., by the public, by the private or by both the public and private (also named 'Hybrid' in our study). In the following section, the components, categorization and characteristics of the different financi and provision strategies will be further deliberated.

Financing and Provision Strategies

Main components

There are two components for healthcare system, which includes financing/funding and provision/delivery. Financing/funding and provision/delivery can be further divided in how its facilitated in terms of resources allocations, in the public sector, the private sector or combination of both.

Hence, it is not an understatement to describe that healthcare systems are dynamic, and rightly so, as they need to cater for changing needs of the population such as ageing population, new government directions/policies/initiatives and technological developments. A matrix on categorizing the different types of provision and financing in the following table is an attempt to divide these various components into different compartments but it is needed to recognise they are from being static. From our study, it is observed that there is not an appropriate categorization in matrix form can represent the latest PPP categorization. The following categorization is derived from the combination of classical model of services financed or provided purely by public or private (Parliament of Canada, 2001) and the recent development of PPP with hybrid structure in the service financing/provision given by both public and private (Asian Development Bank, 2016).

Table 2: Categorization of Financing and Provision of Healthcare Goods and Services

		Provision		
		Public	**Hybrid**	**Private**
Financing	**Public**	• Public Service • Insurance and service delivery are handled by a single public agency. • Norway, Sweden, Denmark, Finland	• Financing by Public • Service Provision by Public and Private	• The public pays for services through taxes or social security and the services are provided by private agencies (commercial or non-profit). • Contracting out • Canada, Japan, Germany, France, United Kingdom
	Hybrid	• Financing by both Public and Private • Service provision by Public • This mode does not exist	• Financing by Public and Private • Service Provision by Public and Private • Government concession with share operation and management	• Financing by Public and Private • Service Provision by Private • The Design, Build, Operate, Transfer (also known as Private Finance Initiatives)
	Private	• The cost is charged directly to users (through insurance or out-of-pocket payments) but services are provided in public facilities. • This mode does not exist	• Financing by private • Service Provision by Public and Private together	• Private Service • Healthcare is funded by private insurance or paid for directly by the patient and is provided in private facilities. • United States

Source: Parliament of Canada. (2001). Public and Private Sector Involvement in Healthca Systems: A Comparison of OECD Countries (for financing and provision purely by pub or private); and Asian Public-Private Partnership Handbook, Asian Development Ba 2016 (for financing and provision in hybrid mode)

In accordance with the World Bank (2012), PPP is a long-term contractual arrangement between a private partner and a government agency to provide public asset or service, the private partner bears the risks and management responsibility. While for the World Health Organization (Kickbusch & Quick, 1998), it defines partnership as a means to "bring together a set of actors for the common goal of improving the health of populations based on mutually agreed principles and roles" (P.69). From the above financing and service provision model, PPP can be public financing with private provision; private financing with public provision; or hybrid financing and provision.

Public financing and provision

Under publicly financed healthcare systems, there are two main types of financing: 1) Tax-based financing; and 2) Social security financing. Taxes are often collected by the government, and the government can also deliver the services such as in Sweden, it is also the dominant mode of financing in healthcare system in Hong Kong. Social security financing are systems with public mandated coverage for designated groups, and can be financed through payroll contributions, semi-autonomous administration, care provided though own, public or private facilities (Parliament of Canada, 2001).

In view of service provision by the private sector with public financing, contracting out is the mo prominent partnership mode. Institutional economics theory addresses that voluntary co-operati

or collaboration between organizations could solve the integration problems (Axelsson & Axelsson, 2006). These could be done through intensive contracts and communications between different organizations provided the organizations are willing to collaborate. Contracting out involves publicly financed investments aiming to improve efficiency and/or quality by awarding a service contract, management contract, construction, maintenance, and equipment contract of various hybrid contracts to a private partner(s). In this type of PPP, the public sector bears the risk of facility development, risk of managing the contract, the operational risk involved in at the private partner side (Roehrich, Lewis, & George, 2014). In Hong Kong, PPP in healthcare service is dominantly in this mode. As such, the public agency, i.e. Hospital Authority and the government still bear most of the risks.

Private financing and provision

Economic theory addresses that a transaction will occur if the demand and supply meet at equilibrium and profit can be optimised at this point. For the private sector, the main business goal is to make profit. In this regard, no matter the service is ultimately provided by either the private or the public, the goal of private financing is to make profit.

There are essentially two main types of private financing: 1) private insurance; and 2) out of pock payments. For out of pocket payments, this is a form of private payment. This can inclu

deductibles or co-insurance items for private insurance schemes. In public insurance schemes, this could include out of pocket payments for extra billing or user fees (Parliament of Canada, 2001). Of course, if there is no public or private insurance coverage, then all the services are paid for by the patient.

In regard to private insurance, participation in a private insurance scheme is voluntary, the insured persons pay a premium and the deductible or co-insurance is usually required to be paid by them. The remaining costs will be covered by the insurer. The premiums are typically based on the level of risk of the insured persons. There are many risk assessment parameters, such as health record, age, gender, other health related factors, etc. Charges for insurance scheme would vary for different insured person. The voluntary private health insurance is the major source of finance in the United States and Australia (Parliament of Canada, 2001).

Mandatory private health insurance is a population-wide medical insurance for all members of the society. While the persons with financial capability could pay their own premium, else it could be subsidised by the government (Parliament of Canada, 2001). In addition to basic level of coverage, additional coverage is available on a surcharge. This option is adopted by Switzerland and t Netherlands.

Hybrid financing and provision

According to literature, in the public health sector, it appears that stable multidisciplinary teams which can sustain over a long of time is the most successful form of inter-organisational collaboration (Health Canada, 1999). In regard to barriers to inter-organizational integration and collaboration, these include, difference in administrative boundaries, different laws, rules and regulations, budgets, financial streams, and different information systems and databases. Different professional and organizational cultures, different values and interests and differences in the commitment of the individuals and organizations involved. (Vangen & Huxham 2003; Glendinning, 2003)

Apart from being purely financed by either the public sector or private partner, and instead of facilitating the provision of service in monetary form, the government could also steer the partnership by providing assistance in other forms, such as setting up ordinance or regulation to facilitate the private partner to provide services, granting public assets for private use, such as land, etc. The private sector will be responsible to develop, operate and maintain the facility afterwards.

Concession is a common mode of private financing in healthcare sector oversea. Concession arrangement with the private sectors (the concessionaire) in which, the existing asset ownersh remains in public hands but where the private partner is responsible for new investments a

maintenance of the assets, the concessionaire has the long-term right to operate the facility and utilise its assets. A typical example is the private partner building the facility and repaid by providing the services over a long period of time. The facility remains owned by the public partner (Nikolic & Maikisch, 2006). Concessions typically shift much of the operational and maintenance risks to the private sector (Roehrich et al., 2014), besides, the government often provides an explicit or implicit guarantee to protect the private partner against the risk of lower than expected revenues or other risks, such as formulating law and regulation to ensure its right to operate and charge.

A similar mode of hybrid financing and service provision is the Private Financing Initiatives (PFIs). The PFI is a distinct means of funding major capital investments in the health sector through financing provided by private partners. The private consortia enter into long-term contracts with the government to finance, build the facilities. The funding of PFI for the private consortia can be in the form of trust, bonds (Nikolic & Maikisch, 2006) In terms of PPP, the public partner would provide some kind of grant to the private partner, such as the right of land use for very long period of time. Since the government only provides the asset, the private bears the development and operational and maintenance cost later on. Financial risks are transferred to the private partners.

The Emergence of Public Private Partnerships

Basic theories

No organization can function without knowing what is happening in the outside world. In the healthcare sector, there are numerous divisions and sub-divisions in specialties; mode of resources allocations and practices, according to contingency theory, the public sector needs to adapt to various scenarios. In order to do so, the public sector in healthcare is needed to separate tasks and roles for the purpose of specializations. However, healthcare sectors also require a high level of integration which in order to make a treatment viable (Axelsson & Axelsson, 2006).

Under organization theory, it is a difficult task for managing organizational relationship between departments within the organization and it is even more difficult for collaboration between different organizations. It is because different organizations have different hierarchies, networks, coalitions and strategies alliances of organization. Differentiations between organizations occur in their functions and structures, also in their attitudes and behaviors (Axelsson & Axelsson, 2006). There is a trend of increasing specialization and professionalization of roles and tasks in public health in the past decades. Its functional differences also led to structural differences.

According to literature, when there is no integration that is required to achieve unity of effort f differentiated tasks or roles, fragmentation occurs. Such fragmentation leads to efficiency a

quality problems. It also refers to integration problems, which include duplications, gaps, inconsistencies or incontinuities in provision of services (Bolland & Wilson, 1994; Glendinning, 2003).

Based on these theories, different financing and provision strategies have emerged to address the need of inter-organizational collaboration with focuses on PPP.

Characteristics of PPP

PPP involves the collaboration between the public and private sector to achieve the goal in healthcare sector, in which transparency, accountability and public interest are crucial. Under such conditions, the government is required to carry out the role of regulator to set quality standards and monitor safety and quality issues to ensure the public can adequate access to the products and services they need (Torchia, Calabro, & Morner, 2015).

Pongsiri (2002) suggests establishing a transparent regulatory framework in which regulations provide assurance to both public and private sector by ensuring partnership operate efficiently and optimizing resources in achieving policy objectives. By examining nine European case studies assess the associated benefits and risks and good practices for ensuring success of PPP and pub private collaboration (PPC), Nikolic and Maikisch (2006) emphasises the crucial role of t

regulatory framework in assuring and promoting the quality of healthcare services resulting from any such arrangements. It also suggests the regulatory framework often needs to be adjusted to accommodate the different types of partnerships and collaboration. Well-defined objectives, clear division of roles and responsibilities, risk allocation and other transaction elements should be agreed among the partners before the implementation of PPP and PPC (Nikolic & Maikisch, 2006). Ongoing monitoring to the pre-agreed criteria and targets, and adjustments of elements based on continuous communications with all partners and stakeholders are required and necessary to the success of PPP or PPC. Nikolic and Maikisch (2006) suggests a single task force, advisory board, and project management office being established for the duration of the project in ensuring continuity in the monitoring and managing of quality and performance.

On the other hand, Blanken and Dewulf (2010) emphasises the importance of the way contractual arrangements being structured and the degree of flexibility allowed in the PPP to enable an adequate respond to the uncertainties. Some features like knowledge and expertise together with the management of the contractual arrangements, and financing mechanism etc. are found to critically affect the flexibility generated in PPP. Contractual flexibility is key in sustaining and initiating commitment in PPP (Wong et al., 2015).

The reasons for entering into PPP

In a PPP context, many partnerships are formed on the basis of financial goals which in order to reduce costs and enhance efficiency. Besides, there are also health objectives where a common goal in fighting a disease exists. The third objective is to expand the access to service in a country and the fourth objective is to develop new, innovative approaches to address public health issues. The public sector mainly focuses on reduce costs, enhance efficiency and reduce risks. In accordance with Canadian Council for Public-Private Partnerships (2011), the risks bearing by the public sectors will decrease when the level of involvement of the private partner increase. When the PPP is in the form of contracting out service, the Public will still bear most of the risks, such as operational, financial risks, etc. When the PPP is in the form of concession, the level of risk bearing by the public will greatly decrease as the private partner will bear the risks such operational and financial risks. For the private sector in the PPP, its goal is mainly the maximization of profit, and run the service as a business and be responsible not only the patients, but also the shareholders. There is obviously a situation of objective mismatch between public and private sector.

Relations between partners and other stakeholders

The term "partnership" of PPP describing the relationship between public and non-public acto seems to imply an equal status and authority for the actors involved. As mentioned, WHO defin partnership as a means to "bring together a set of actors for the common goal of improving t

health of populations based on mutually agreed roles and principles" (Kickbusch & Quick, 1998). Under this definition, maintaining a balance of power between the parties is considered important so each could preserve its core values and identities and other ethical principles like autonomy (Buse and Walk, 2000). The unbalanced partnerships bring risks to the relationship between partners and the unbalanced partnerships may result from the lack of well-defined roles, the information and power asymmetry between public and private sectors (Torchia, Calabro, & Morner, 2015; Wong et al., 2015). Reducing the power asymmetry between partners, clearly defined objectives and roles, transparency and frank information, and communications relating to risk and benefit for partners and stakeholders are found to be critical in producing effective PPP, and sustaining and initiating commitment in PPP (Torchia, Calabro, & Morner, 2015; Wong et al., 2015).

Building of trust is found to be one of key factors in initiating commitment in a partnership and sustaining PPP (Wong et al., 2015). Effective partners are found to go beyond formal or legal contractual relationships and rely on informal coordination, trust and social capital in the network (Singh & Prakash, 2010). The values, objectives and principles of private and public sectors are diverse, and therefore communications platforms are needed for developing common understandi trust and negotiation (Koppenjan, 2005). According to the conference held by the Asi Development Bank Institute in 1999, both private and public partners need to focus on syste

improvement and enhance information sharing for mutual benefits (as cited in Mitchell, 2008). The system must be able to create incentives for sustainable relationship.

Stakeholders' involvement is also found to critical for relationship building. The relationship between partners could be strengthened through regular consultation and sharing of information (Singh and Prakash, 2010). The extent and nature of the stakeholders' involvement therefore affect the effectiveness of PPP. The systematic review of PPP by Roehrich et al. (2014) suggests that the management of stakeholder relationships is critical for developing collaborative partnerships. Lack of internal and external stakeholders' involvement causes problems across PPPs (Roehrich et al., 2014).

Evaluation of PPP as Hybrid Financing and Provision Arrangements

Evaluation criteria

PPP have become a common approach to address healthcare problems worldwide aiming to improve the quality of healthcare services and efficiency of service delivery. Like other government instruments and policies, evaluation of PPP is therefore necessary to bring insights to public officials in designing and implementing PPP and to enhance its effectiveness.

As far as the evaluation of public policy is concerned, the approach for evaluation of public poli

proposed by Vedung (2006) is employed here. Evaluation is a mechanism for monitoring, systematizing, and grading government interventions so that public officials and stakeholders can act in a most responsible, innovative, equitable and economical manner (Vedung, 2006). The interventions could be policies, programmes, projects and provision of services etc. According to Vedung (2006), evaluation is defined as follows: "careful assessment of the merit, worth, and value of content, administration, output, and effects of ongoing or finished government interventions, which is intended to play a role in future, practical action situations." (Vedung, 2006, p. 397).

To start with, the criteria under the evaluation framework developed by Vedung (2006), the Eight Problems Approach to Public Policy Evaluation, are mainly employed to assess PPP – programme output (effectiveness), cost (efficiency) and process (Due process). These criteria are also commonly identified in the evaluation of public interventions and tools (Baldwin, Cave, & Lodge, 2012; Salamon, 2002). PPP differs from the traditional public delivery and tools in many aspects like financing arrangement and close relationships and collaborations between public and private parties (Ho & Tsui, 2009). There are regulating roles of government as public side. It is important to evaluate the establishment of transparent legal and regulatory framework and the degree of flexibility allowed. In relations to partnership, there are partners and stakeholders, a therefore issues of trust power relations become critical.

Effectiveness

Effectiveness, which assesses the extent to which an action achieves its institutionalised goals and intended objectives like public health improvement, is the most basic criterion for measuring the success of public intervention (Salamon, 2002). Effectiveness, being irrespective of cost, demonstrates the recognition of the legitimate and democratic aspect of public-sector goals (Vedung, 2006). However, it is difficult to measure effectiveness as programme objectives are often quite obscure and ambiguous, and the precise indicators in practical are usually difficult to identify (Salamon, 2002). Sometimes other several goals may be potentially conflicting to one another (Vedung, 2006).

To assess the programme output and effect, Vedung (2006) identified other client-oriented criteria besides goals to respond to clients' concerns, like service availability, service quality, service process, service administration and service impact on themselves. For example, does the specific PPP provide higher quality of services? Does it result in cheaper services that facilitate the accessibility and availability of services to public? These criteria, as a supplement to the goal criteria, cater for clients' needs. This will further enhance the legitimacy of the policy and quality of service, which in turn improve the effectiveness of the policy. The term "effectiveness" he broadly refers to the both goal and client criteria evaluation.

Efficiency

Efficiency, one of the economic merit criteria proposed by Vedung (2006), addressing the relationship between intervention expenses and essential output and impact. Efficiency shows the value of intervention effects per cost, which helps achieve the optimum balance between benefits and costs. In other words, efficiency means to achieve goals and objectives at the least possible level of inputs or costs and it is a kind of productive efficiency (Baldwin, Cave, & Lodge, 2012). The costs that are relevant to a judgement about the efficiency of a tool are not only those spent by the government side, but also the costs incurred by the other parties due to the policy (Salamon, 2002). So it suggests the total cost of the intervention is needed to be taken into account.

Cost saving is one of the main and important justifications and reasons for the implementation of PPP. Its value for money in general results from the greater innovation and efficiency of private sector and risk being transferred to the private sector. It might also take in the form of increasing resources or reductions in costs through contracting. Therefore, it seems to be more advantageous for the financial arrangement of PPP than traditional public financing arrangement from the value for money perspective but just not the financial contribution of the private partner to the PPP.

Due process: equity, transparency and public/stakeholders' involvement

Process criteria including legality, equity, publicity, representativeness and procedural fairne

addresses the quality of the procedures of the intervention (Vedung, 2006). Goal attainment should be balanced against deliberative democracy and client involvement during the process.

According to Salamon (2002), equity has two meanings. Equity could refer to the basic fairness – the distribution of benefits and costs more or less evenly among all those eligible. It also involves redistribution the benefits to the disadvantaged, and ensure equal opportunity and access to all in the society. It might be a concern whether the private sector may attempt to maximise its profits by focusing attention to the wealth. Could the PPP provide quality services to different sectors of the public?

Baldwin, Cave and Lodge (2012) reckoned one of the criteria for good regulations are due process. The procedures used are fair, accessible and open. It thus not only focuses on the equality, fairness, openness and consistency of the procedures but also on the level of public /stakeholders' participation during the process and decision making (Baldwin, Cave, & Lodge, 2012, pp. 29). The democratic influence is ensured and thus enhances the legitimacy. More guiding principles of participation, for example, who being able to participate, in what manner and to what extent, will therefore be set up. The outcome obtained in due process may not agree with that by expertise a professional judgement.

The partners in the successful PPP need to be accountable to each other and to the public for the quality of services they offer (Mitchell, 2008). The PPP could be evaluated whether the partners provide enough information for public to make informed choice and involve in planning and monitoring of services.

Regulatory framework and flexibility

Apart from the three sets of criteria, a PPP could be assessed if there is an enhanced regulatory environment and a robust legal framework through which regulations are enforced, so as to properly monitor the quality of services, accessibility and costs (Torchia, Calabrò, & Morner, 2015). Also, it is important to evaluate the degree of flexibility allowed in the system which enhances its swift response to the environment.

A PPP relationship can span over a very long period of time, sometimes over 30 to 40 years. It is unlikely for the public or the private partner to know exactly the situation of the environment tens of years later. An agreement with rigid clauses would cause a hold up problem for which either partner, would be difficult to exit from the relationship when there is changing of service provision environment or during financial difficulty. Flexibility in regulatory framework is therefore ve important to the success of a PPP (Torchia, Calabrò, & Morner, 2015). The regulatory framewo is applied through, the establishment of legislation, contract, or deed. With a good framewo

with flexibility, the project scope or magnitude can be adjusted or fine-tuned in accord to prevailing situations which enabling a continuous compliances and benefits from the PPP relationship.

Without a flexible regulatory framework, the scopes of service and the performance or the private partner in the PPP cannot be brought up to the status which can cope with the current situation. This will lead to high transaction costs. Transaction costs include a hold-up problem for which the outdated scopes in the contract established years ago cannot be flexibly amended but the private partner would only adhere to the clauses as specified in the original contract (Ho & Tsui, 2009). The services provided are no longer value-for-money. Ceasing or amendment of contract would incur very high transaction costs for compensating to the private partners. To some extents, if the performance of the private partner is not satisfactory but the performance controlling mechanism was not specified in the contract, the costs for supplementing the inefficiencies would be very high as well. In the United Kingdom experience, the projects in the mode of Private Finance Initiative (PFI) would even need the government to bailout due to the financial difficulties in the trust (Plimmer & Neville, 2014).

Collaborative relationships

The collaborative relationship between partners and stakeholders could be assessed in terms these aspects: common understanding, clear objectives and responsibilities, goal alignment, mutu

trust building, balanced power relations, sharing of information and management of stakeholders' relationships (Buse & Walk, 2000; Nikolic & Maikisch, 2006; Koppenjan, 2005; Roehrich et al., 2014; Singh and Prakash, 2010; Torchia, Calabrò, & Morner, 2015)

In the subsequent chapter 4, the logic and strategies of mixing of the five PPP cases chosen are analysed. In each case, the financing and provision arrangements concerned are described. The cases are assessed according to the above five sets of criteria.

Synthesis of Analytical Framework

In the analytical framework, a thorough study on the nature of goods has been conducted. The analysis begins with classifying healthcare services as toll goods via the analysis with accessibility and availability of service provision. With this backbone, the financing and provision for the healthcare services has further been studied. In the study, it is observed that healthcare services can be delivered with different strategies, for which, when it is publicly finance, the tax payers will bear all the cost, but the cost of healthcare can still be maintained at a lower level. On the other hand, when it is privately financed, the patient will bear all the costs but the charge will be higher in private facility.

In healthcare policy, everyone must be able to receive healthcare service. For this purpose, public sector would never be able to adequately provide healthcare service for everybody's use, therefore, using the resources of private sector can be a way out. This is the emergence of PPP - there is a need for the public and private partners to collaborate. They are willing to collaborate because there is public gain from enhancing service provisions, where the private partner gains from the profit generated from PPP. The literature reviews provide lots of studies on PPP from different perspectives, for example, risks transfer; effectiveness and efficiency; regulatory framework and flexibility, collaborative relationships, etc. All of the theories which applied to the PPP set the basis for evaluation on service provision and financial arrangements. From this basis, the following eight criteria are further addressed and will be used to evaluate specific PPP:

- Have the services/programme met the goal?
- Are users satisfied with the services?
- Do the services achieve cost saving purpose?
- Is the provision of service equitable?
- Is the provision of service transparent?
- Does the planning and setup have ample public/private involvement?
- How is the government and private sector relationship?
- Is the monitoring on provision of service effective?

The above eight questions used to evaluate the PPP are transformed from the evaluation criteria (i.e. effectiveness; efficiency; due process; regulatory framework and flexibility and collaborative relationships) as mentioned in the literature. Asking these questions for evaluating the PPP under analysis will be able to tell whether the PPP is successful. The evaluation of PPP will be carried out in Chapter 4 during the mini-case study.

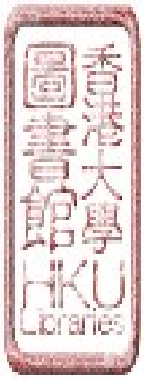
Upon evaluating the selected PPP, together with other analysis such as the Hong Kong Healthcare System and Policies in Chapter 3 and study of overseas PPP experiences in Chapter 5, the appropriate way forward for sustainable development of PPP of Hong Kong in financing and service provision aspects will be recommended.

Chapter 3 Hong Kong's Healthcare System and Policies

Introduction

An analysis is provided in this chapter of the healthcare policy of Hong Kong and its history in past 20 years, including significant development and reform brought by the Scott Report, Rainbow Document and the Harvard Report together with the development of HA creation and clustering. The analysis is guided and informed by the elements of the analytical framework established in Chapter 2.

Significantly, in 2013, Hong Kong spent 5.4% of its GDP on healthcare, with 47.6% spent on the public healthcare sector and 52.4% spent on the private healthcare sector. Hong Kong has long been a user of the dual-track healthcare system where there is a combination of public and private financing and provision of healthcare services. Hong Kong also prides itself with healthcare expenditure as percentage of GDP being relatively low compared to other countries.



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Australia (1)	8.6	8.5	8.5	8.5	8.8	9.0	9.0	9.2	9.4	9.4	
The mainland of China (1)	4.7	4.7	4.6	4.4	4.6	5.1	5.0	5.1	5.4	5.6	
Hong Kong SAR (2)	5.5	5.1	4.9	4.8	4.7	5.0	5.2	5.1	5.2	5.4	
Japan (3)	8.0	8.2	8.2	8.2	8.6	9.5	9.6	10.1	10.2	10.2	10.2
New Zealand (1)	8.0	8.3	8.7	8.4	9.3	9.8	10.0	10.0	10.2	9.7	
Singapore (1)	3.2	3.7	3.6	3.4	3.9	4.3	3.9	3.9	4.2	4.6	
South Korea (3)	5.0	5.3	5.8	6.0	6.2	6.7	6.8	6.8	7.0	7.2	7.4
Taiwan (4)	6.2	6.3	6.3	6.2	6.5	6.9	6.5	6.6	6.6	6.6	
Denmark (1)	9.7	9.8	9.9	10.0	10.2	11.5	11.1	10.9	11.0	10.6	
Finland (3)	7.9	8.1	8.0	7.8	8.0	8.8	8.6	8.6	9.0	9.1	9.3
France (1)	10.9	10.9	10.9	10.8	10.9	11.6	11.6	11.5	11.6	11.7	
Germany (3)	10.4	10.5	10.4	10.2	10.4	11.4	11.3	10.9	11.0	11.2	11.3
Italy (1)	8.5	8.7	8.8	8.5	8.9	9.4	9.4	9.2	9.2	9.1	
Norway (1)	9.6	9.0	8.6	8.7	8.6	9.7	9.4	9.3	9.3	9.6	
Spain (1)	8.2	8.3	8.4	8.5	8.9	9.6	9.6	9.4	9.3	8.9	
Sweden (1)	9.1	9.1	8.9	8.9	9.2	9.9	9.5	9.5	9.6	9.7	
Switzerland (1)	11.0	10.9	10.4	10.2	10.3	11.0	10.9	11.1	11.4	11.5	
United Kingdom (3)	7.7	7.9	8.0	8.1	8.5	9.4	9.1	8.9	8.9	8.8	
Canada (1)	9.6	9.6	9.7	9.8	10.0	11.1	11.1	10.9	10.9	10.9	
United States (3)	15.2	15.2	15.3	15.6	16.1	17.1	17.1	17.1	17.1	17.1	

Table 3: Total Expenditure as percentage of GDP. Reprinted from http://www.fhb.gov.hk/statistics/en/statistics/health_expenditure.htm, 2016

Given the level of spending aided by low fees and charges in the public healthcare sector, Hong Kong has achieved remarkable results. It has an average life expectancy of 83.48 as reported by the World Bank (The World Bank, 2016) and with 1.7 registered infant deaths per 1000 registered live births in 2014. (Department of Health, 2016)

These remarkable public health metrics achieved are the envy of many public health government officials around the world.

Hong Kong has not always enjoyed such great success with its healthcare system. During the 1960s and 1970s, Hong Kong was faced with a myriad of issues - growing demand for healthcare coupled with rising community healthcare expectations, centralised management of healthcare and with few healthcare facilities resulting in overcrowding and camp beds, there was low staff morale for healthcare professionals, with inequity for access of healthcare and no community involvement for healthcare.

Healthcare Goods and Services

Given the situation in the 1960s and 1970s, with limited resources from the government, much of the healthcare services and provided and sought by the community was with the private sector. Hence, during this time healthcare provision in Hong Kong arguably could be regarded as a private good and service. The availability was therefore very limited taking into account the restraint of public resources and limited supply of private healthcare services.

Due to the limited healthcare services by public sector, the accessibility was of concern, which w adversely affected by the structural barrier, i.e. the limited number of hospitals, the undevelop

public transportation to access to clinics / hospitals and a lack of registered medical practitioners, etc. The low-level household income also placed a financial barrier to access to healthcare services. In the absence of sound financial abilities, the public found it very difficult to meet the insurance premium and subscribe insurance plan, where access to private healthcare services was hindered.

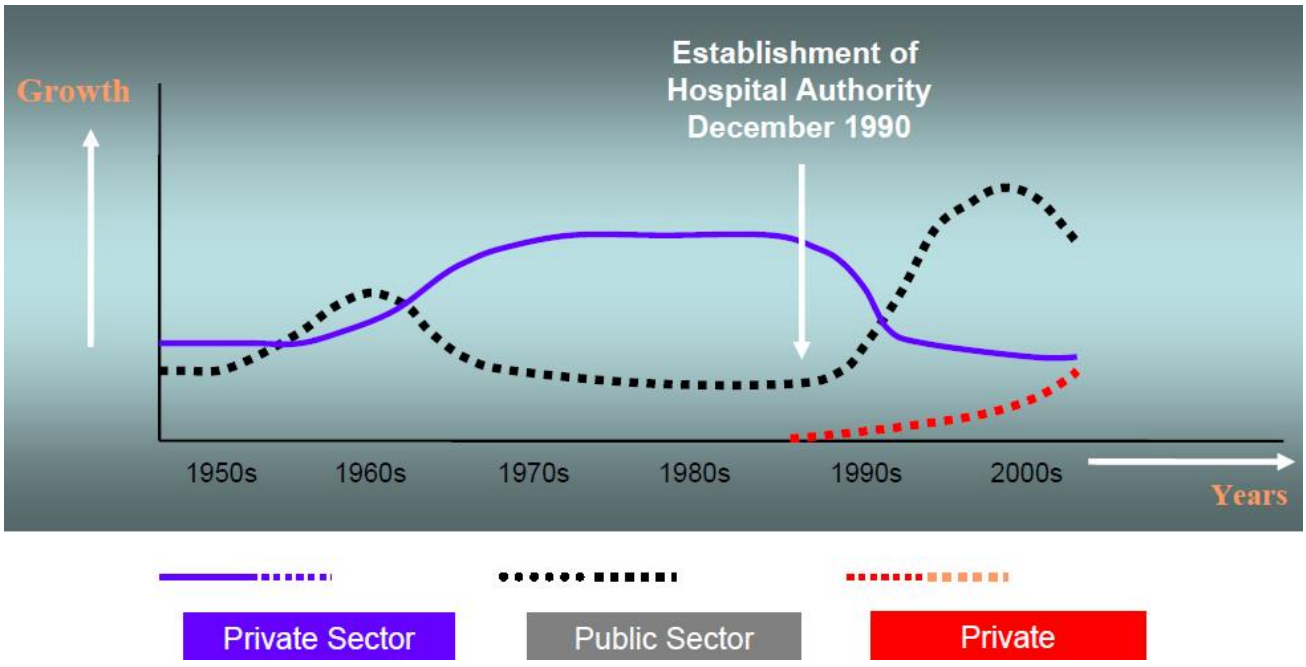


Figure 1: Hong Kong Health System Development in Past Decades. Reprinted from "The Hong Kong's Healthcare Reform in the Past Two Decades" by G. Lieu, 2004, The Institute for Health Policy and Systems Research

Given the growing concerns to address this myriad of challenges at the time, the Hong Kong Government embarked on its first major healthcare reform with the Scott Report in 1985. This w pivotal in its suggestions with splitting the then Medical and Health Department of Health into tv separate Departments – Department of Health (DH) and Hospital Services Department. It al

advised to restructure fees and charges to recover ~20% of costs in public hospitals and with reform in public hospitals management.

Based on the suggestions from the Scott Report, this paved the way for the establishment of Hospital Authority as a statutory body in December 1990. It then assumed the management of all public hospitals by December 1991, commissioned with the responsibility to strengthen hospital governance and management infrastructure with greater responsibility and implementation of modern healthcare practices.

In 1993, a further review of the Hong Kong healthcare system was undertaken with the 'Rainbow Document'. The Rainbow Document was targeted at reviewing the funding policy for healthcare in Hong Kong. One particular principle which was suggested was 'No one should be denied adequate medical treatment through lack of means.' Since then, equity for healthcare in Hong Kong was more achievable healthcare was then transitioning to be a toll good. It effectively set a cornerstone in providing better availability of healthcare services and greater accessibility with reduced structural and financial barriers to access (Hedley, 2001).

The Rainbow Document is a key document and monumental time point in Hong Kong's healthca system. It set the direction and foundation that healthcare in Hong Kong must be equitable and th

no one should deny adequate treatment lack of means. This essentially shifted healthcare services in Hong Kong to be toll goods that the Hong Kong Government would be the final gatekeeper and responsible in ensuring that this is met for all Hong Kong people. As such, the Rainbow document identified the need to expand constraints and limitations of financing and provision of healthcare in Hong Kong at the time.

Financing and Provision Strategies

The Rainbow Document in 1993 identified different public health issues, with limited patient choices, inequitable fee structure, and limited public/private collaboration/partnerships. The Document addressed the concerns by outlining primarily five different strategies – two different methods of charging fees based on different selected patient groups, two different methods of funding of healthcare through insurance and another method with prioritizing resources allocation.

The Rainbow Document paved way for the Harvard Report in 1997, which concluded that the current healthcare system at the time would not be the best for future public interest for patient's health in Hong Kong. However, the observations were that most public healthcare services were supported by government budget, and the majority of the public health provisions were in-patie healthcare.

Taking a look at the data collected in 2010/11 by Hong Kong Domestic Health Accounts and look at the financing of the public and private healthcare sector. In public healthcare funding, we can see that 93% is from the Government budget, with the remaining as household out-of-pockets funding. In private healthcare funding, we can see that 65% is from household out-of-pockets funding, with approximately 30% as insurance payouts. It is safely concluded that Hong Kong government has been following the public financing based on charging tax payments and those having financial difficulties would be supported by the social security system in Hong Kong, i.e. Comprehensive Social Security Assistance (CSSA) Scheme.

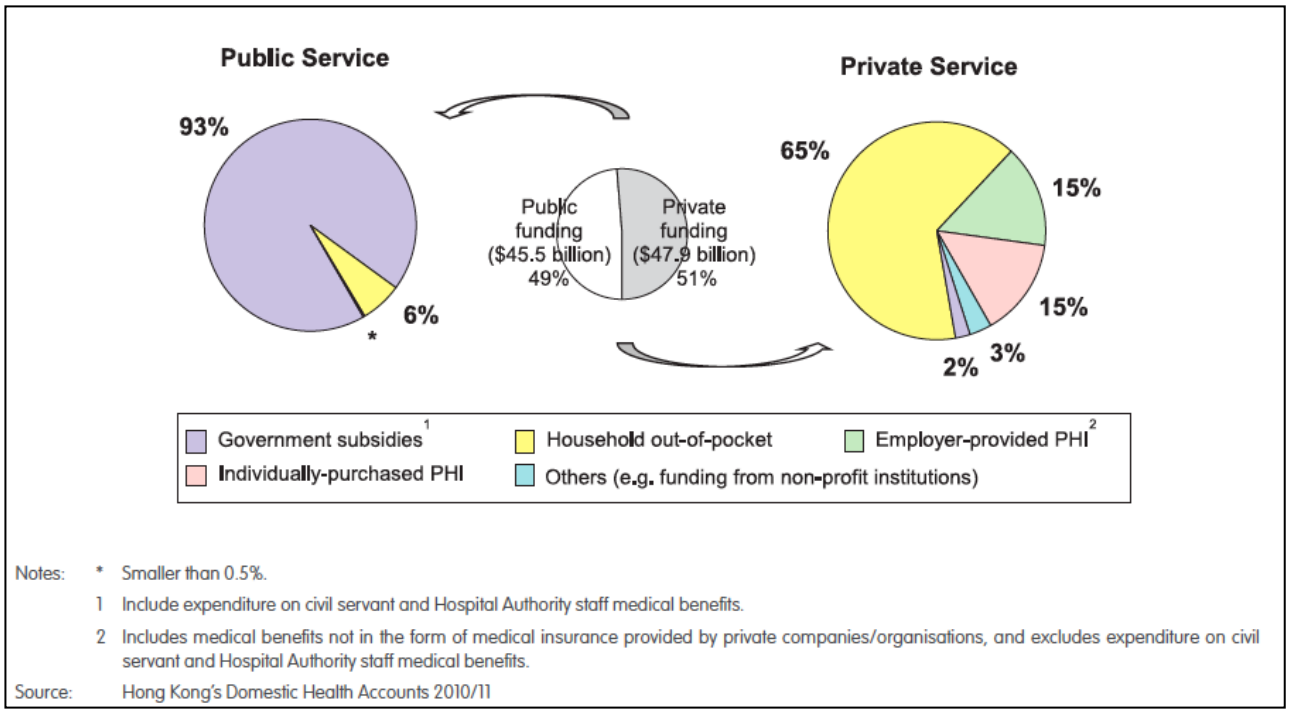


Figure 2: Distribution of sources of financing for public and private healthcare in Hong Kong. Reprinted from Hong Kong Domestic Health Account 2010/11, 2016. Retrieved from http://www.fhb.gov.hk/statistics/en/dha.htm

Using in-patient services as a measurement and by calculating the number of bed days, it observed that 88% of services are being provided by public hospitals, with the remaining 12%

services as being provided by private hospitals. When looking as out-patient services as the measurement and by calculating the number of out-patients attendances, we can see that 70% of the services are being offered by the private sector, with the remaining 30% of the services being provided by the public sector.

In the last decade, there has been substantial increase on the healthcare services supported by the Government budget. There has been an increase on the recurrent annual expenditure on medical and healthcare services from $32 billion in 2007/8 by over 60% to $52 billion in 2014/5. The growth in government spending in medical and healthcare service became disproportional to the tax payment or income / revenue received from the government. These measures are considered not effective enough in addressing the healthcare challenges. With government funding alone, it cannot confront the upcoming healthcare challenges in Hong Kong, with an ageing population, rising medical costs and greater public expectations on quality of healthcare services. That was why it was observed that the government started adopting the model of contracting out on non-essential or ancillary service of public healthcare sector, such cleaning and security related jobs in hospitals. It was no surprise that the administration is trying to adopt more hybrid financing and provision models. The hardcore problem needs to be further complemented by measures in the priva sector, for example the hybrid model in form of PPP in financial and provision arrangement. mentioned earlier in chapter 2, more and more hybrid mode of cooperation arises in the commun

including concession and PFI, where the prominent example in the new hospital Gleneagles to be discussed in the next chapter.

Through the Rainbow Document it identified in order for equitable healthcare to be achieved, further measures to be taken to explore different financing and provision strategies which paved way for the first Harvard Report in 1997. The Harvard report in 1997 dwelled on a greater emphasis that the Hong Kong Healthcare System was not sustainable and that further strategies were needed to explore different financing and provisions. In this report, it paved the way for the second Harvard Report in 1999, which was the early foundation work for PPP for Hong Kong's Healthcare system, after which PPP developed and evolved into being any types.

Types of Public Private Partnership

Prior to the development of PPP, the healthcare services sector in Hong Kong is largely government-oriented. Most healthcare services were provided by the government, while a small portion was separately provided by the private sector. The Harvard Report in 1999 was regarded as the important document to bring forward the PPP development. It focused on suggestions for a reform of the Healthcare Financing and Provisions mainly through a series of different PPP a further development of the private health sector. It recommended higher user fees for HA, a lo term designated savings accounts for healthcare, wider range of development for primary outpatie

services for the greater integration of public and private sectors through contracting certain services to reduce waiting times in HA.

In 2003, there has been introductory guide on PPP put forth by the government until the first PPP programme, namely Cataract Surgery Programme in 2008. In effect, the collaboration in PPP requires ample flexibility, clear objective, defined roles and responsibilities, risk allocation and building of trust. In the absence of these elements, implementation of PPP won't be achieved in an effective and efficient manner.

In 2008, an official healthcare reform document was done to promote PPP and with a secondary consultation on the need to improve capacity and transparency of private healthcare services. While the public healthcare sector focuses on cost reduction and enhancement of efficiency and the goal of private sector is profit maximization, the mismatch should hinder to the cooperation to a certain extent. It is therefore of essence to achieve an optimal balance in the PPP under a regulatory framework.

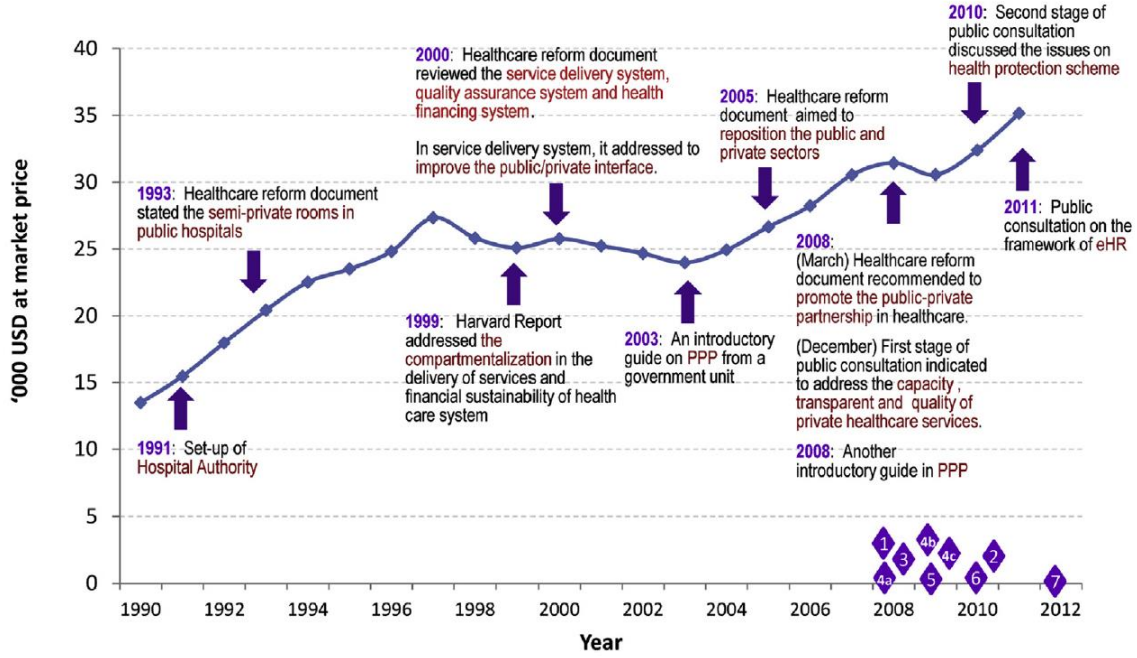


Figure 3: Milestone of PPP development in Hong Kong, 1990-2012. Reprinted from "How shall we examine and learn about public-private partnerships (PPPs) in the health sector? Realist evaluation of PPPs in Hong Kong" by E.L.Y. Wong, E.K. Yeoh, P.Y.K. Chau, C.H.K. Yam, A.W.L. Cheung, & H. Fung, 2015, *Social Science and Medicine*, 147, 261-269.

The first ever PPP project in Hong Kong was implemented in February 2008, followed by Health Care Voucher Scheme in 2009 and Outreach Primary Dental Care Services for Elderly in 2011. Hence, an evaluation of PPP is possible after 2008.

Evaluation of Hong Kong Healthcare System

Our prospective under this section would be adjusted to look at the Hong Kong healthcare policy in the past with an evaluation of the Hong Kong's healthcare system. As we've taken written a listed about the development of Hong Kong's healthcare system through the various consultatio and reports, one would perhaps have the impression that there are myriad of issues plagued wi

Hong Kong's healthcare system. Is that the reality? How does Hong Kong compare with other countries? How does Hong Kong's healthcare system perform?

To evaluate, let us take a look on some data. In accordance with to CIA world fact book, Hong Kong's life expectancy at birth of 82.9 years ranked sixth in the world in 2015 (Central Intelligence Agency, 2015). In another ranking by the United Nations (2015), Hong Kong's life expectancy at birth of 83.7 years ranked the top of the world in 2015.

This achievement has been certainly attributed to the government commitment in injecting a large sum of capitals into the healthcare sector, providing adequate and accessible services to everyone in need. In particular, the establishment of HA in 1990 had brought substantial improvement in the healthcare policy in terms of effectiveness and efficiency (Food and Health Bureau, 1999).

In the early colonial period, the administration adopted a laissez-faire approach to public health. Provision of health services largely hinged on the market, with partial funding from the government as start up. But still, there was a clear health policy in the 1950's. One would generally complain the overcrowding problems and long waiting time in public hospitals. The growing demand of hea care services, rising cost and community expectation make the situation more worse a complicated. In 1964, the government detailed a long-term development plan on healthcare sect

including building more hospitals, expanding the subvented sector and increasing the bed-to-population ratio to 4.25 per 1,000. With the recommendation be implemented in several reports, HA implemented a series of measures, including expanding outpatient to poor and low income families, raising the user fee and enhancing the handling capacity of medical services. (Food and Health Bureau, 1999)

As the quality from of our healthcare services improved in particular with our public healthcare services since the establishment of Hospital Authority, how has Hong Kong done with cost-effectiveness in public healthcare spending? From 2004 to 2014, Hong Kong was spending an average of 4.7% to 5.5% of its GDP on healthcare as a community. This compared to other OECD countries, we would be considered one of the countries which spent proportionally the least amounts of our GDP on our healthcare, yet also enjoying very good healthcare as eluded to earlier in our public healthcare metrics.

According to LU and Edney (2014), Hong Kong was ranked first and second in the ranking of 'Most Efficient Healthcare Systems in the World' in 2013 and 2014 respectively. Is healthcare in Hong Kong and with the establishment of Hospital Authority considered perfect then? One would need perhaps look into greater detail into the evaluation of Hospital Authority to answer this question. fact, recently there was a review of Hospital Authority and of its operations during the past 20 ye

done by the Hong Kong Government. The report concurs that Hong Kong indeed enjoys a cost-effective public healthcare system (Food and Health Bureau, 2015c).

It identified several key areas that needed further strengthening/action in order for Hospital Authority to be a more cost-effective organisation for patients, staff and the Hong Kong community:

- To strengthen governance and in rationalizing the overall HA structure
- To enhance greater equity and transparency in resource management
- To have greater consistency in staff management and in allowing greater staff development
- To allow for provision of better services as measured by HA's KPIs
- To have better safety and quality of services

In addressing these key areas for improvement during the government's evaluation of the performance Hospital Authority, a response and action plan was formulated (Hospital Authority, 2015a). It would be worthy to note the progress of the implementation of the action plan and to evaluate the effectiveness of the measures taken. Yet, evaluating public healthcare service is or half the story. What about the evaluation and development of private healthcare services? Furth

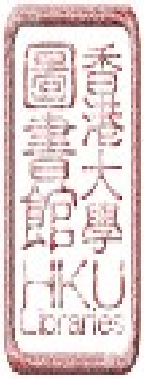
data is needed for the evaluation of private healthcare services, and more is shared on the development of private healthcare services in the subsequent chapters.

Concluding Comments

In this chapter, the key changes in the development of Hong Kong's healthcare system were highlighted. From the Scott Report, which highlighted the importance and governance between different healthcare authorities in Hong Kong at the time to the creation of HA, creation and clustering based on the Scott Report.

The Rainbow Document was a key document in incorporating a key principle into Hong Kong's healthcare system which paved the way for healthcare to also be transitioned into a toll good, by highlighted that equitable healthcare needed to be provided. It was also the Rainbow Document that highlighted a range of financing and provision issues and the need for reform, which gave rise to the Harvard Report in 1997 and the second Harvard Report in 1999.

The second Harvard Report in 1999 paved the foundation for the development of PPP in Hong Kong's healthcare system. In the next chapter, we hope to use our collected empirical data analysing five recent examples of PPP with the analytical framework we developed in Chapter 2.



Chapter 4 Case Study of Public Private Partnership

Introduction

In this chapter, five case studies of various PPP models in Hong Kong are presented. The analysis, as with that in Chapter 3, is guided and informed by the main elements of the analytical framework established in Chapter 2.

The following five examples are chosen as part of our empirical study in evaluation of PPP in Hong Kong, as they represent types of collaboration and with different government bodies.

Hong Kong Gleneagles Hospital represents a more recent example and development of a new type of PPP where the Hong Kong Government partially subsidised the land cost as it was sold a lower rate arguably compared to normal commercial land use. The management however is entirely run by a private operator, but during the tender a certain percentage of its services needs to be under the fee structure of Diagnosis-Related Groups (DRGs) which encourages greater transparency in fees.

HA's Cataract Surgeries Programme is evaluated as perhaps one of the more successful rece examples in execution and evaluation of it as a PPP. It is a programme under HA which responsible for the public healthcare provider to most of the Hong Kong public. It also highligl

the key steps in paving the foundation under HA for a PPP setup and in allowing further development of other PPP with other services in HA.

Tung Wah Group of Hospitals is chosen as an example of study as the longest serving NGO partners for healthcare in Hong Kong. It epitomises the key developments of healthcare changes and also has witnessed the changes of Hong Kong's healthcare system. It also has a history and experiences in developing a range of healthcare services under various forms of PPP that it has collaborated with the Hong Kong Government. It is also the only example of the five case studies, where it has its own ordinance that offers the foundation of Tung Wah's philanthropic work in Hong Kong.

Food and Health Bureau's (FHB) Elderly Health Care Voucher Scheme is chosen as an example as its managed under FHB which is the Bureau that directly manages the healthcare system in Hong Kong. Hence, it would be interesting to analyse the executive and the collaborations it has fostered given the direct control of the scheme by FHB. It is also the scheme that has been vigorously evaluated by different studies as commissioned by the Government and concluding its effectiveness and future direction.

.

The pilot project on outreach dental care services for elderly at residential care homes and day ca

centers is administered by DH. It would be interesting to see how different administering bodies differ in its execution and collaboration. It also mainly works with non-governmental organisation partners in the provision of dental care services rather than a wide range of private practitioners.

With these five examples we hope to have a broad spectrum of data collected on the different types of PPP administered by different government bodies and at different time points in Hong Kong and in addressing different key healthcare needs.

Gleneagles Hong Kong Hospital (GHKH)

Background

GHKH is being branded by Parkway Pantai, it majority shareholder and management, as a tertiary private hospital with comprehensive services for Hong Kong citizens. It will be operating in early 2017 and will have 500 beds and over 35 specialties and subspecialties. The hospital will also be encouraging a more transparent and affordable fee structure, with a designated proportion as diagnosis-related-group fee for patients.

Goods & services: accessibility and availability

In this setting, GHKG would be seen as a toll type of goods and service with characteristics of public sector collaboration, which is the Li Ka Shing Faculty of Medicine of the University of Hong Kong (HKU), and with limited accessibility and availability. There is a total of 500 beds in the hospital and doesn't have other hospitals in its network in Hong Kong. If the occupancy is full, it would have to be refuse admission to patients. One would presume that they could gauge a suitable level of available services to the patients by adjusting the prices of its services, under private market dynamics (Glenagles, 2016).

Financing & provision strategies

The current site being used for GHKH was first planned in 1993, to be called a 'Canadian International Hospital & Technology Exchange Centre of Hong Kong' and was being planned by a group of Hong Kong Canadian physicians (Wong, 1993). The site was then cleared in 1994 by the government, where it was used formerly the site of Nam Fung temporary housing area. However, plans were not realised and the site was left vacant for over two decades (LegCo, 1995).

The Hong Kong Government in 2009 launched sites to encourage the development of priva hospitals, to promote a healthier balance of in-patient private services being provided by priva hospitals. These sites opened for different healthcare providers to submit EOI (expressions

interest) in the different sites.

The Wong Chuk Hang site was most popular with 12 different providers expressing interest (Ng 2010). However, as the process moved into open tender in 2012, many of them did not participate in the tender as there were difficulties in the economy as well as difficulty as expressed in meeting the various tender requirements.

One measure the Hong Kong Government has been encouraging in the private hospitals, has been the use of standard package prices for common diagnoses/diseases, this was an incentive to encourage greater transparency and competition in private hospitals, with the aim of greater usage of in-patient private hospital services.

One of the difficulties that different providers had difficulty in seeking if it was financially viable, as part of the tender, 30% of the in-patient services provided at this site was to be with standard package prices (Cheung, 2012).

In 2013, the tender was eventually awarded to Gleneagles Hong Kong Hospital Limited f HK$1.69 billion (HKSAR Government Press Release, 2013). It is a joint venture with a to investment cost of HK$5 billion, and with contributions from Parkway Pantani and NWS Holdin

60% and 40% respectively.

Indeed, it has been a long ordeal for the Wong Chuk Hang site before being commissioned to being the current stage of being built. It is anticipated the GHKH will be operating in early 2017, and with provide 500 beds, with advanced medical technologies and a wide range of clinical services. Hence, GHKG's financing is private as well the provision of healthcare services which is also private.

Type of public private partnership

GHKH is a unique public-private-academic partnership, with the land cost being designated for hospital use and sold at a discount compared to commercial use. It is also a joint venture between two commercial companies, and the Li Ka Shing Faculty of Medicine of HKU, will be an exclusive clinical partner, by overseeing clinical governance, providing clinical expertise and healthcare training. As the Li Ka Shing Faculty of Medicine of HKU is a government subsidised organization, the provision of services of GHKH is therefore in Hybrid mode with collaboration of public and private partners.

Evaluation of public private partnership

In evaluating GHKG as a public-private partnership for healthcare financing and provisions Hong Kong, as the GHKH is yet to be operational in early 2017, it would be difficult to ascertain it would meet the goals initially envisioned by the Government, if services are equitable and if use

are satisfied with the services. It would be useful to do an interim review or preliminary review in 1-2 years of hospital operation, to see if it meets the interim/preliminary targets the Hong Kong Government had for GHKG.

Using such a venture for public-private partnership, it would be more cost-saving for the Government then if it had built its own hospital, as the infrastructure/investment cost will be coming from the private consortium. Further evaluation in how effective GHKH is in delivering in-patient hospital services for the Hong Kong public.

Arguably, if the Hong Kong Government had to offer more land to more providers to provide the same amount of in-patient hospital services than if it had just kept the Wong Chuk Hang site for public hospital use and build it itself. Having to source more land for private healthcare providers, could ultimately mean less revenue collected by the Government by selling land for commercial use, and could also be a greater social cost for Hong Kong collectively, as less land is available for housing and could further drive up the cost of housing. This could arguably result in Hong Kong collectively have less cost-savings than if it built a public hospital, but much more data needs to be collected before further deliberation can be done.

With the implementation of a certain percentage of clinical services to be offered as standa

package prices, it would allow for greater transparency for patients and in allowing them to have a better idea of the fees for in-patient private healthcare services. This would allow for greater patient autonomy and would hopefully allow more patients more choices for healthcare services. Ultimately, we hope to see more patients have greater choices in the provision of healthcare services, between the public and different private healthcare providers.

During the initial expressions and of interest and final tender process, there was ample consultation between the Hong Kong Government and different private healthcare providers. The Hong Kong Government enjoyed a reasonable relationship between local and overseas private healthcare providers, as during the initial period of expressions of interest, we can see there were over 12 different expressions of interest for the Wong Chuk Hang site.

After the tender was awarded, as the Hong Kong Government had required a certain percentage of standard package prices to be offered in GHKH, it meant the Hong Kong Government still had some reasonable input into the range of standard packages prices offered in the private healthcare market. However, the operation and governance of the hospital is entirely a private-academic partnership. Monitoring of the clinical services would be provided by the private hospital operat with Parkway and possibly NWS Holdings, and with Li Ka Shing Faculty of Medicine Univers of Hong Kong as an executive provider. The safety of the clinical services offered would also

monitored by the Department of Health as mandated by law. However, the quality of the clinical services would be difficulty to be monitored by the Hong Kong Government, yet given they are financed and operated privately, one would presume that there is a financial incentive to ensure high quality of clinical services.

Overall observations

GHKH at this stage would be a considered to be a successful public-private partnership model. It terms of effectiveness, transparency, public/private involvement, government involvement and monitoring, GHKH would be considered as being successful as this stage. It is anticipated that the greater transparency of fees with part of the fees to be under Diagnosis-Related-Groups (DRGs) structure would affect healthcare delivery in Hong Kong.

Further data to be collected and observed once the hospital opens in early 2017 would be required to analyse to see if further development of hospitals under this type of public private collaboration should be fostered.

Cataract Surgeries Programme (CSP)

Background

With the growth in the ageing population in Hong Kong, the cataract patients have also been on an increase and the waiting time for cataract surgery in public hospitals was ever growing. Table 4 showed the exceptional long waiting time for cataract patients in early 2008.

Table 4: Waiting time for cataract surgery in public hospitals (as of 31 March 2008)

Cluster	Waiting Time (Months) (As of 31 March 2008)
Hong Kong East	30
Hong Kong West	37
Kowloon Central	56
Kowloon East	127
Kowloon West	10
New Territories East	26
New Territories West	27

Source: Provision of Cataract Surgeries in Hospital Authority (Hospital Authority & Food and Health Bureau, 2013b).

Goods and services: accessibility and availability

In mid-2000s, the availability of provision of cataract surgeries was relatively limited when comparing to the demand. In other words, the demand for cataract surgeries in the public hospit was far more than the actual supply by HA. Each year, there will be 25,000 to 30,000 new catar cases, versus the capacity of cataract surgeries of 16,000 in the financial year of 2007-08 (Food a Health Bureau, 2013b). During this period, accessibility to the cataract surgeries had been mu

hindered. With CSP, it aimed to alleviate the undue waiting time of cataract patients on the list, by providing subsidy to the patients to shift them to the private health sector in order to promote availability and accessibility.

The eligibility is simple and publicised. According to the official website of CSP launched by HA, cataract patients who were on Hospital Authority's cataract surgery waiting list on or before a specified period and are suitable for anesthesia surgeries would be invited. Priority will be given to the patients with the longest waiting time on the list. Cataract patients who are eligible will be able to access the healthcare services.

Financing & provision strategies

Against the scarce resource, CSP has been implemented in February 2008 to provide alternative for cataract patients to perform cataract surgeries in private ophthalmologists. Eligible cataract patients on the waiting list of cataract surgery in public hospitals will be invited. Priority will be given to those who had waited for a long period of time in public hospital. Under CSP, cataract patients will receive a fixed amount of HK$5,000 and may need to pay no more than HK8,000 to private ophthalmologists for the service package of the surgery. The figures from HA (Hospital Authori 2016) revealed that more than 15,000 have undergone the cataract surgeries as at May 2015. In ca of financial barrier where patients are not capable of paying the $8000, HA would invite tho

cataract patients in need to undertake surgeries in public hospitals outside normal clinic hours.

Type of public private partnership

As the pioneer in PPP model in Hong Kong, CSP has been operated under service contracting as the policy instruments. As mentioned, CSP is driven by copayment by cataract patients (not more than $8000) and subsidy granted by HA (fixed subsidy of HK$5000). Service delivery from the private ophthalmologists includes a cataract surgery, pre-assessment consultation and two post-operative checks (Wong, et, 2015).

By contracting out the cataract surgery to private ophthalmologists with financial incentive to the patients, CSP achieves better allocation of public resources by shuffling some cataract patients who have better financial capacities to private healthcare market. This programme improves the imbalance between public and private healthcare services, optimizing the use and capacity of private sector. Other cataract patients on the waiting list are able to undertake the surgery earlier.

Generally speaking, the risk factor of this PPP model is very limited. All private ophthalmologists taking part in CSP have to be Ophthalmology Specialists registered in the Medical Council of Ho Kong. The ophthalmologists in CSP are required to strictly follow the "Guidelines on Infecti Control Practice" tailored made for CSP. Clinical outcomes and complications of the surgeri

could be monitored. Following the surgeries, patient satisfaction survey will be conducted by HA.

Evaluation of public private partnership

Among the evaluation, as regards effectiveness, the measurement is whether the goal set has been achieved. One of the major reasons of the implementing CSP was to shorten the waiting time. CSP virtually offers subsidy for elderly to choose taking operation in private clinic, providing an alternative, and helped other cataract patients indirectly by shortening the waiting list and notional waiting time in HA. So far, based on the information from HA (Hospital Authority, 2016), 15,600 performed the operation under the scheme. In comparison with the waiting time between 2008 and 2016, one could easily agree that the goal of CSP has been met effectively. Table 5 shows the waiting time as of 31 March 2016 in which waiting time of almost all of the HA fall below 24 months (except Kowloon West). The effectiveness aspect of CSP is in no doubt very satisfactory.

Apart from waiting time, CSP also helped to address the imbalance between public and private sectors in healthcare services provision. Given heavy usage and limited capacity of public healthcare system, CSP as the initiative of PPP enabled better use of the service capacity in the private sector, and in turn more effective use of resources in public hospitals.

Table 5: Waiting time for cataract surgery in public hospitals (as of 31 March 2016)

Cluster	Waiting Time (Months) (As of 31 March 2016)
Hong Kong East	8
Hong Kong West	12
Kowloon Central	20
Kowloon East	14
Kowloon West	30
New Territories East	17
New Territories West	23

Source: Waiting Time for Cataract Surgery Posted in HA Website (Hospital Authority, 2016).

Regarding users' satisfaction HA has been very much concerned of the service delivered by the private ophthalmologists. By way of telephone survey after the surgeries, cataract patients participating in CSP were contacted and the result / feedback was very encouraging. With reference to HA's official website, as at May 2015, 4,652 cataract patients had been randomly surveyed, 4,338 patients (93% of patients) were satisfied with CSP. 4,644 patients (99% of patients) agreed that CSP assisted to have undergone the surgeries earlier. Similarly, from the user's perspective, CSP has been effective and successful.

When it comes to efficiency, the information on costs and benefits of CSP should be available for detailed calculation. Without concrete statistical analysis, it may be hard to draw a conclusion th if the programme achieves the cost saving purpose. In the absence of concrete data, we mig have the idea of efficiency qualitatively. For each cataract patient, as mentioned in precedi

paragraphs, HA will provide a subsidy to encourage them to undergone the surgeries in private sector. When comparing the medical costs in public hospitals, it is safe to conceive that such costs incurred should be far more than the subsidy so that it would be wise to encourage more cataract patients to flow to private sectors.

The provision of service has been equitable. The eligibility of CSP patients are explicitly listed in its official website, including the duration already on the waiting list, medical condition and priority criteria, etc. Eligible cataract patients will receive invitation letter and decide to take part in CSP on a voluntary basis. The information of the number of invitation letters sent and the group of recipients are available online.

The provision of service is remarkably transparent. The fees are clear and certain. With the subsidy, the cataract patients are only required to pay a fixed amount no more than $8000. More than 100 participating ophthalmologists are all registered with the medical authorities and the list is uploaded onto CSP's website, where the patients could freely make their own choices. It simply provides additional choice and alternative route to have cataract surgery on voluntary basis. The after surgeries survey enabled the CSP more accountable and transparent.

To initiate the idea into actual implementation, HA conducted a series of consultation of the loc

groups and associations, including patient groups, Private Hospitals Association and College of Ophthalmologists, etc., to collect opinion and information of willingness to join the new programme (Hospital Authority, 2007). As the pioneer in the PPP, support from the private ophthalmologists and its professional body are of paramount importance to make this happen. The ophthalmologists need to agree the fees paid by the cataract patients, types and number of services included and liability issues. It is regarded that the stakeholder involvement is significant during the planning and set up, whereas the public involvement is not uncertain as there are not much empirical data available.

By reference the waiting time and users' satisfaction, CSP is considered as a successful programme and PPP model. The cooperation between the government and private sector is particularly important during the setup and planning stage. It sets a cornerstone in ensuring a smooth implementation of CSP. The division of labour is clear after the implementation, where the private sector largely follows the contract and agreement made with HA and the administration conducted reviews and handled all administrative matters.

Similar to transparency, monitoring on provision of the healthcare service under CSP is effecti
First of all, all private ophthalmologists engaging in CSP have to be registered Ophthalmolo
specialists in the Medical Council of Hong Kong. Apart from registration, the priva

ophthalmologists also are required to comply with the "Guidelines on Infection Control Practice" under this programme. Thanks to the Electronic Health Record Sharing System, the clinical outcomes and complications in respect of the cataract surgeries performed by the ophthalmologists could be monitored. The HA, as covered in earlier paragraphs, is conducting effective monitoring work on the ophthalmologists through patient satisfaction survey after the surgeries.

Concluding Observations

In conclusion, in various aspects and under different evaluation criteria, CSP is considered to be a successful PPP model by service contracting in particular the effectiveness, which significantly has reduced waiting time for cataract surgeries in public hospitals and successfully achieved a social objective. In micro level, the users' satisfaction, equity, transparency and monitoring, CSP also achieved very fruitful result without dispute. CSP, in broader sense, even brings implication and stimulus to further PPP development.

As HA's pilot PPP programme it has shown effective results with clearly defined metrics and in reducing the waiting times for cataract surgery. This is well received in the public, LegCo and by HA.

Tung Wah Group of Hospitals (TWGH)

Background

The Tung Wah Group of Hospitals (TWGH) is the oldest charitable organization which provides free medical services in Hong Kong. The TWGH was established and operating under provision of legislation and regulation, the Hong Kong Law Chapter 1051 Tung Wah Group of Hospitals Ordinance (hereafter 'Cap 1051'). Under Cap 1051, one of the major objectives of the corporation is to provide the inhabitants of Hong Kong with free or affordable medical services (Hong Kong Law, 1971).

Goods and Services

The TWGH has joined the Hospital Authority (HA) since 1 December 1991. Under the HA structure, the five TWGHs operate the hospitals as the same mode as other HA hospitals. Similar to other HA hospitals, it is possible to restrict someone's access to TWGHs' services because of limited capacities. Besides, as mentioned above, medical services are vital to the society and it is always available for subsequent consumption or use by someone else. Therefore, the services provided by TWGHs are toll goods.

Financing & Provision Strategies

According to TWGH Annual Report 2015-16, the government had subsidised the TWGHs

provide medical and health services with an amount of $15 million, while for the same period, the expenditure of the medical and health services was about $2.1 billion. The shortfall of the funding is from donations and other sources such as rent receivable or investment income (Tung Wah Group Hospitals, 2016). The financing of the PPP between the government and the TWGHs is therefore in a hybrid mode.

In regard to service provision, there are 2650 beds in these five hospitals, 600 of these beds are provided by the TWGHs which are free for those really in need. The rests are provided in the mode as other hospitals of HA subsidised by the government (Tung Wah Group Hospitals, 2016). The service provision is in hybrid mode.

Type of Public Private Partnership

The government has played a major role to establish Legislation to facilitate the TWGH to operate with sufficient resources. In particular, as stipulated in Cap.1051, the TWGH is empowered by the Ordinance to get sufficient funding through fund raising by charity, investment and rent receivable (Hong Kong Law, 1971). This is a concession given by the government.

In term of risks analysis in the concession, for the public sectors, as HA managing the five hospita of TWGH, the government bears the operational risks for any malpractice in medical service. F

example, a baby fell out of an incubator at Kwong Wah Hospital in May 2016, the Official of FHB was needed to respond to the incident and conduct investigation (Information Services Department, 2016), it might also be accountable for civil claims.

In financing points of view, as mentioned before, a large portion of funding on medical and healthcare is from sources other than government subsidies due to the fact that a large portion of funding is generated from charity, property investment, etc. According to the annual report of the year 2015-16, after deducting from its expenditure, there were still 338 million of surplus for the TWGH and it was totally allocated to provide new services or new developments in the Group. The possibility for failure in this PPP is very unlikely.

Evaluation of Public Private Partnership

For evaluating the PPP, as stipulated in Cap.1051, one of the objectives is to provide free and affordable medical services, although the TWGH can only provide 600 fee beds for those in need, the general and specialist out-patient medical services are also free for the public, the hospital will pay the HA for the required fee on behalf of the patient (Tung Wah Group Hospitals, 2016). The goal is therefore considered attainable.

In accordance with 'Patient Experience and Satisfaction Survey on specialist outpatient 2014', t

overall experience for 26 HA hospitals was very good, 84% of patients in the survey rated 7 points out of a 0-10 scale (Hospital Authority, 2014a). In '2013 Hospital-based Patient Experience and Satisfaction Survey', the overall inpatient experience was also very good, with 86% rated 7 points and above out of a score of 0-10 (Hospital Authority, 2013a). 4 out of 5 hospitals of the TWGH are target hospitals in these surveys. In this regard, the patients are satisfied with the services provided by TWGH.

The medical and healthcare services that the TWGH provides are following the protocol of service provisions under the HA system, under the system, all statistics for waiting time; patients' satisfaction survey, medical malpractice, etc., are available to the public at very early manner (Hospital Authority, 2016). The services provided are highly transparent. In regard to the equitability, there are criteria for receiving the free services provided by TWGH, such as financial difficulties encountered by the patients. According to the website of TWGH, it provides fee waivers for CSSA recipients for their medical expenses during hospitalization. Other people in need with financial difficulties may also apply for a waiver. Therefore, the charge for the same treatment to different patients might be different, but the services provided to the patients for the same treatment will not vary.

The PPP relationship between the government and the TWGH was established more than 100 yea

ago, the collaborative system has well maintained. Prior to the enactment of the Hong Kong Law Cap.1051 in 1971, the Laws of Hong Kong had been guiding the TWGH in its operations and made it sustainable. The Tung Wah Hospital Incorporation Ordinance was acted in 1870. In the Ordinance, the Tung Wah Hospital had already been empowered to own land and properties for investment or lease out. The Ordinance had been replaced by the Tung Wah Hospital Ordinance, Chapter 317, and listed all the land lots they owned at that time (HKU, 2016). No matter the Ordinance of which era, the major objective of the TWGH is to provide free medical services. Without the empowerment of TWGH to get the financial sources by owning land and properties and fund raising, the TWGH will not be able to provide free or affordable services.

In the Ordinances of different time, all of these specified that the composition of the board of directors and the function of the board. The management of the TWGH is heavily relying on the board members (Tung Wah Group Hospitals, 2016). The PPP relationship with the government is cohesive since the management of medical and healthcare services are carried out by both the TWGH and the HA. Without a strong involvement of TWGH, the Ordinance could not be drafted and the drafting process must have involved the inputs from TWGH. As there is great flexibility for the TWGH to get it funding, for which the government fully supports and also subsidises provision of services. The relationship between the TWGH and the government are therefore us to be very good.

Overall observations

All in all, the PPP between the government and the TWGH is a concession in hybrid mode. The Ordinance empowers TWGH to get funding from varies sources, for example, investments to properties and lease out properties, which make the TWGH is financially sustainable. In this regard, the TWGH can maintain its objectives for providing free and affordable services which facilitating accessibility of service provision.

In the analysis on outcome of service provisions, the 'Hospital-based Patient Experience and Satisfaction Survey' showed that the patients are satisfactory with the service. Since the TWGH is under HA, the outputs of 5 hospitals of TWGH definitely enhances the accessibility of service provision as a whole.

In regard to risk bearing, as it is under HA mechanism, any upgrading of service or extension of facilities will be the responsibility of the government for which the funding would still need to be granted via an established government procurement procedure, the construction risks are borne by the government. In operation, the government is accountable for any malpractice and might fa litigation raised by the claimant. The operational risk is still borne by the government.

The PPP between the government and TWGH is considered a successful one, even though the government is still risk adverse in many aspects, the financial capacity of TWGH is high, the PPP in concession with hybrid mode is sustainable. The PPP between the government and TWGH is successful. The most important factor for its success it the availability of regulatory framework which ensuring the best interest for both the government and the TWGH. In the long run, the government should consider further shifting risks, such as management and operation risks, to TWGH in return of giving out more concessions to the PPP under the provision of the Ordinance.

Elderly Health Care Voucher Scheme (HCVS)

Background

The Government launched the pilot of Elderly Health Care Voucher Scheme (HCVS) in 2009 to subsidise Hong Kong residents aged 70 or above to use private primary care services including preventive care. HCVS later was converted from a pilot project into a regular programme in 2014. The annual voucher amount has increased from $250 to $2,000 for an eligible elder. The face value of each voucher has lowered from $50 to $1 in 2014 and the ceiling of accumulated voucher amount has increased from $3,000 to $4,000 each year to offer greater flexibility for elders in using the vouchers. By March 2016, 5,300 healthcare service providers are enrolled under HCVS a over 610,000 elders have used the vouchers (Food and Health Bureau, 2016b).

Goods & services: accessibility and availability

Elders aged 70 or above who hold valid Hong Kong Identity Card or Certificate of Exemption are eligible to participate in HCVS. 10 categories of healthcare professionals registered in Hong Kong including medical practitioners, Chinese medicine practitioners, dentists, chiropractors, registered nurses and enrolled nurses, physiotherapists, occupational therapists, radiographers, medical laboratory technologists and optometrists are eligible to participate in the HCVS. The eligible citizens can use the vouchers at any of participating private healthcare centres which provide the mentioned primary care services within their local communities or in other districts. Table 6 shows the service provided by Medical Practitioners and Chinese Medical Practitioners is accessible in each district.

Table 6: The distribution by districts of the enrolled Medical Practitioners (EMPs) and enrolled Chinese Medicine Practitioners (ECMPs) (August 2014)

District	Number of places of practice (Note 1)	
	EMPs	ECMPs
Southern	40	48
Wong Tai Sin	77	104
Sham Shui Po	92	128
Kwai Tsing	102	75
North	52	80
Sha Tin	117	117
Eastern	155	140
Kowloon City	129	93
Kwun Tong	210	191
Islands	32	24
Tai Po	81	105
Yuen Long	138	70
Tuen Mun	116	135
Sai Kung	115	72
Tsuen Wan	132	137
Central and Western	167	112
Wan Chai	136	171
Yau Tsim Mong	325	329
Overall	2,216	2,131

Sources: Audit analysis of Department of Health (DH) and Planning Department records (as cited in Audit Commission, 2014, pp.42)

Note 1: Some EMOs/ECMPs had more than one place of practice.

DH launched a publicity programme to encourage private healthcare service providers to enroll in the HCVS from November 2011 to May 2012 to enhance the popularity of HCVS. According Audit Commission (2014), the enrolment rate was increased by 18% in 2012, further enhancing t accessibility and availability of the services. The conversion of the pilot project to a regu programme in 2014 has made the provision of service continuously available for citizens. Starti

from 6 Oct 2015, eligible elders can also use their vouchers in more service points in mainland - designated medical centres of HKU – Shenzhen (HKU – SZ) Hospital, further increasing the accessibility.

Financing & provision strategies

HCVS is typically a programme of public financing and private provision. The Government rolled out the pilot of HCVS to provide additional choices for elderly on top of existing public primary healthcare services to enhance the primary healthcare services for elderly through collaboration with the private sector. The service is subsidised by the Government through issuance of vouchers and is delivered through the enrolled healthcare professionals (EHCPs) under HCVS. The elderly make use of the vouchers to pay the service they received, and DH will make payments to EHCPs after receiving their claims.

Types of public private partnership

The type of PPP involved in HCVS is contacting, in particular, purchase-of-service (POS) contracting. According to Salamon (2002), POS contracting involves "an agreement under which a government agency enlists a private organization to deliver a service to an eligible group of clien in exchange for money" (Salamon, 2002, p. 320). To protect the interest of elders and mainta the quality of service, the participating private healthcare service providers are required to comp

with the terms and conditions of the HCVS agreement, for example, they have to ensure the voucher amount consumed does not exceed the fee for the healthcare service received by an elder; otherwise, the voucher claims will not be reimbursed by the Government.

The Government bears considerable of risks like managing the agreement and operational risks involved in the private healthcare providers. As the Government is ultimately accountable for the cost and quality of the contracted healthcare services delivered through vouchers, it is necessary to conduct monitoring and evaluation (Salamon, 2002). From mid-2013 to mid-2016, DH received a total of 34 complaints about the HCVS, including operational or administrative procedures, and suspected deception or improper voucher claims by service providers etc. (Food and Health Bureau, 2015a).

Evaluation of public private partnership

Regarding the evaluation of effectiveness, the assessment is focused on whether HCVS has achieved its intended objectives. HCVS aims at providing partial subsidies for elderly to receive private primary healthcare services in the community under the concept "Money follow Patient" with a view to enhancing the provision of primary care service for the elderly due to the le burdened on public primary healthcare services (Food and Health Bureau, 2011a). It also seeks promote utilisation of preventive healthcare services and concept of shared responsibility f

healthcare among elderly. The total number of elderly who had made use of HCVS vouchers has increased progressively from 551,000 in December 2014 to over 610,000 in March 2016, accounting for 75% and 80% of eligible elders respectively (Food and Health Bureau, 2015a; Legislative Council Secretariat, 2015b). However, from 2009 to 2013, less than 9% of vouchers were used for preventive care purpose like giving health advice and health assessment which had been, however, always emphasised by the Government in the context of HCVS (Audit Commission, 2014)[1]. It seems HCVS fails to increase the use of preventive care. Only one percent of elderly used the vouchers for general body checks (Cheung, 2015). It might be difficult to change the habit of the elderly within several years. The intended objectives might have just been partly met.

About the users' satisfaction, FHB collected feedback from the participating and non-participating elderly about HCVS in the interim review, and elderly in general were satisfied with HCVS. At the initial phase, the operation had encountered various problems, concerning the use of electronic platform and unclear information etc. These had quickly been identified and addressed, and the operation had been streamlined. To join HCVS, the elder just has to show their HKID to an

[1] The purpose of preventive care had been always mentioned by the Government like the updated paper of the Legislative Council Panel on Health Services on 2011 and in the 2011 interim review.
As stated in updated paper of the Legislative Council Panel on Health Services on 2011 (see para. 11), "The Administration advised that it (HCVS) attached great importance to strengthening preventive care for the elderly".
http://www.legco.gov.hk/yr10-11/english/panels/hs/papers/hs0314cb2-1220-5-e.pdf

As stated in the 2011 interim review (see para. 4.7), "the elderly are less willing to pay for preventive care than episodic care. This is a conception that has taken root among the elderly, and takes time and the concerted effort o all – Government, healthcare service providers, the media, etc. – to gradually induce a cultural change that puts mor value and emphasis on preventive care."
http://www.hcv.gov.hk/files/pdf/ehcv_interim_review_report_en.pdf

enrolled healthcare service provider and sign a consent form. 65% and 64% of elderly (including both users and non-users) considered the HCVS useful and convenient to use respectively. 79 and 80% of the voucher users find it useful and convenient to use. Other opinions of the elders had been addressed already, for example, 28% suggested adding optometrist to the list of participating healthcare professionals (Food and Health Bureau, 2015a).

There are no concrete figures showing HCVS's efficiency. However, it is observed that HCVS is cost-effective in some perspectives. First, elderly can select healthcare service providers that best match their own preferences. The availability of choices might probably result in efficiency gains due to greater competition among suppliers (Salamon, 2002, p. 455). The number of healthcare service providers joining HCVS increased from 3,627 in end of 2012 to 5,300 in March 2016 (Food and Health Bureau, 2016b). The result of increased competition provides incentives for service providers to offer high-quality services at least possible cost to expand their market share (Salamon, 2002). Second, the scheme is administered through an electronic platform, eHealth System, which performs various functions like managing immense information, enrolment and reimbursement processes and monitoring. The establishment and refinement of this system has provided a highly efficient platform for administering subsidies for healthcare services to public and has benefit other PPPs (Food and Health Bureau, 2011a).

To maintain equity in the provision of healthcare services, the Government is carefully balancing the coverage, the interest of a particular group and the benefits of the society as a whole. There have been strong request from the public, medical professional associations and legislative councilors for lowering the eligible age for using the vouches to 65 as well as increasing the annual voucher amount (Food and Health Bureau, 2015a, 2016b; The Hong Kong Medical Association, 2015)[2]. The Government consistently expressed the need for further assessment of effectiveness of HCVS and the long-term financial implications for three fold (Food and Health Bureau, 2016b). First, Hong Kong is now facing ageing population challenges. Elders aged 65 and elders aged 70 or above will reach 1.4 million and 0.93 million respectively, which is twice and 1.5 times of the existing number of elders using the vouchers (Census and Statistics Department, 2015). And, there is no income and asset assessment of users. The current average life expectancy of people in Hong Kong is around 80 years (Census and Statistics Department, 2015). It is anticipated that both the number of elders using the vouchers and the annual financial commitment would increase significantly. Second, the average amount of vouchers used by an elder in 2014 and 2015 was 1,260 and 1,711 (Food and Health Bureau, 2016b). Third, it seeks to promote the shared responsibility of healthcare among public. The equity of the service has been enhanced further by allowing Hong Kong residents residing in Mainland to use health care vouchers at the HKU-S

[2] 70% of the elderly and 80% of the caregivers supported reducing the eligible age for HCVS from 70 to 65 while 64% of the caregivers thought $2,000 was insufficient and proposed increasing it to an average amount of $4,000. Survey on Elderly Health Care Voucher Scheme, The Hong Kong Medical Association, 20 April 2015 http://www.hkma.org/english/newsroom/news/20150420.htm extracted on 26 May 2016

Hospital.

The delivery of service is transparent in general. Elders are provided with a "Notice on use of Health Care Vouchers" indicating the voucher amount before visit to healthcare professionals, claimed for the visit and the remaining amount after visit. The voucher balance can also be checked through different channels like website and enquiry hotline. The enrolled healthcare service providers would display a scheme logo outside their practices for easy identification.

The engagement of the private sector in the logistic arrangement of HCVS improved considerably to a more acceptable level. When private sector's initial engagement in HCVS was low, they expressed concerns in different areas like the length of the registration process and refused to support HCVS actively (Wong et al., 2015). The top-down arrangement and imbalanced power relations between the private and the public in the beginning led to mistrust and false expectation. Efforts were later made in enhancing the communications between the public and the private sector. The Government collected feedback from healthcare service providers (both enrolled and non-enrolled) about HCVS during the interim review. The improvement of communication and relationship was reflected in the considerable increase in the participation figure. The number healthcare service providers joining HCVS increased from 3,627 in end of 2012 to 5,300 in Mar 2016 (Food and Health Bureau, 2016b).

The monitoring on the provision of services is effective in general and the measures have been enhanced after the interim review being conducted and implementing the suggestions by Audit's Report. The Government has implemented monitoring mechanism for checking and auditing vouchers claims of HCVS, including routine checking, monitoring and investigation of irregularities found in transactions etc. Since HCVS was launched in 2009, DH has checked 210,000 claim transactions which cover 90% of the enrolled healthcare service providers with claims made (Food and Health Bureau, 2015b). 121 anomalous cases relating errors in procedures or documentation were identified in the checking. The eHealth system has been enhanced to pick up potential anomalous claims and give alert messages for irregularities (Legislative Council Secretariat, 2015b). Starting from 2012, service providers are required to input the information on the amount of fee they charged into the eHealth System for voucher claims for analysis (Food and Health Bureau, 2013b). In response to the comments in Audit's Report No. 63, the DH has refined its regulating measures like compiling and analysing the statistics to facilitate timely feedback to the healthcare service providers to enhance their compliance (Audit Commission, 2014, p. 58, para 4.37; Legislative Council Secretariat, 2015a).

Overall observations

HCVS in general would be considered to be quite successful. It has successfully shifted about 80 of the eligible elderly population to use private primary healthcare services to meet the needs

elderly while alleviating the burden of public healthcare system. In terms of users' satisfaction, equity and transparency, HCVS performed well. The health care vouchers can be used for various kinds of private primary care services and this may bring a certain degree of difficulties in setting standard fees and monitoring like the items of fees included and levels of fees charged by private service providers (Food and Health Bureau, 2015a). However, the monitoring mechanism has been established and continuously improving. Stakeholders' engagement and relations with stakeholders have improved to a satisfactory level.

Pilot Project on Outreach Primary Dental Care Services for the Elderly in Residential Care Homes and Day Care Centres

Background

In Hong Kong, elders have low tendency to have dental healthcare services. According to the Oral Health Survey 2011 (Department of Health, 2011) only about 22.3% of the elderly, aged 65 to 74, in the community had regular dental check-up habit. Meanwhile, the same survey showed that the oral health of this group of elders was in a deteriorating trend with only 19.3 teeth on average and 5.6% of them had total tooth loss, comparing to the 35 to 44-year old adults group with 99.8% of whi had above 20 teeth left. For the elderly in Residential Care Homes (RCHs) and Day Care Centr (DCCs), it is understandable that a higher proportion of them have physical and cogniti

impairments, thus resulting to a worse oral heath than those non-institutionalised. According to the same Survey, 29.6% of these elders had total tooth loss and a mean of 9.4 teeth remaining.

Accessibility to dental services is always a major issue to the elderly, particularly for those residing in RCHs and DCCs. Due to their physical and cognitive impairments, the elderly are unwilling and not able to take a long trip to dental clinic (regarded as structural barrier), and do not recognise their need of dental services (regarded as personal barrier) respectively. Eventually, their dental problems may be ignored and not properly be treated. Next, financial constraints is another reason which may hinder the elderly's from seeking primary dental check-up or even dental treatment. Moreover, delivery arrangement of the elderly to dental clinic may reluctantly be provided by RCHs and DCCs due to various reasons, e.g. lack of staff and transportation, involvement of additional expenses, etc.

In 2011, the Government launched a three-year "Pilot Project on Outreach Primary Dental Care Services for the Elderly in RCHs and DCCs" to provide free outreach dental services to the elderly living in RCHs and DCCs. The main objectives were to promote oral health to the elderly in RCHs and DCCs; provide oral care training to the caregivers; and provide free primary dental care services including dental check-up, scaling, polishing and any other necessary pain relief a emergency dental treatments to the elderly in RCHs and DCCs on-site (Food and Health Burea 2011b).

Goods & services: accessibility and availability

As mentioned before, there are different kinds of access barriers for the elderly to dental services. The implementation of the pilot project was able to reduce structural barrier by implementing the dental services with outreach nature (Food and Health Bureau, 2012) and providing suitable transportation with escort services to dental clinics should sophisticated support be required, reduce personal barrier by pro-actively provision of primary dental check-up and then subsequent follow-up curative dental treatment, and reduce financial barrier by providing subsidised services and applying on behalf of the elderly the necessary financial assistance, e.g. dental grant under the CSSA, various charitable funds from NGOs, etc. (Legislative Council Secretariat, 2013a). Democratic Party Legislator Mr. CHEUNG Man-kwong supported that the project was capable of providing free regular check-ups for the elderly and allowing those eligible for CSSA to receive curative treatment subject to professional judgement of dentists of the outreach dental teams (Legislative Council Secretariat, 2011). Meanwhile, the Government had intended to ensure continuous availability of the required services under the project by assessing the NGOs' track record as a charitable organization and in providing dental care services, and their capability and preparedness to be an outreach dental services provider (Food and Health Bureau, 2011b).

Financing & provision strategies

The pilot project was fully subsidised by the Government, public funding was granted to t

selected NGOs in form of subvention in an annual basis. To deliver the project, the Government had systematically engaged NGOs as collaborating partners to provide free outreach primary dental care services to the elderly. It is a typical type of public financing and private provision services, i.e. the funding is provided by the Government and the services are provided by the involved NGOs. To ensure the services quality, the participating NGOs were required to meet certain qualifications requirement to become a partner, i.e. must be a bona-fide NGO with exemption from tax under Cap 112 Inland Revenue Ordinance; and was operating or had concrete plan to operate dental clinic for the provision of dental care services to the public (Food and Health Bureau, 2011b).

Type of public private partnership

The type of PPP of the pilot project is contacting out with contractual arrangement between the involved NGOs who provided the services and the Government who provided funding. In this type of PPP, the Government is not able to avoid the risk of managing the contract and the operational risk. First, it was necessary to uphold the quality of service by the Government by closely monitoring the service provision in accordance with the contract clauses. During a LegCo panel meeting on health services on 17 June 2013, Hong Kong Federation of Trade Unions Legislator Miss Alice MAK urged the Government to pay more efforts to monitor the service quality provid by the participating NGOs after having received some complaint cases from the elderly and th family members regarding the below-standard outreach dental services (Legislative Coun

Secretariat, 2013b). The Government still bears the risk of managing the contract.

Second, the pilot project might not able to engage sufficient number of participating NGOs for providing full coverage in the Territories and/or the outreach services might not be operated continuously by the NGOs due to insufficient of funding and manpower. Such concerns, which might lead to failure of the pilot project, were not only indicated by the Government but also raised by some legislative councilor. Independent Legislator Mr. CHAN Kin-por expressed concerns in respect of insufficient participating NGOs and inadequate of resources for the selected NGOs to implement the project during a LegCo panel meeting on health services on 10 January 2011 (Legislative Council Secretariat, 2011). At that time, the Government responded that there should be sufficient interest from the 20 number of NGOs, with dental clinic being operated and/or outreach dental services being provided to the public, to participate the project, and the potential NGOs had been consulted of the estimated amount of allocated resources. However, according to a reply from the Government to written question raised by independent Legislator Dr. LEUNG Ka-lau for the estimates of expenditure 2014-15, only 13 NGOs had setup a total of 24 outreach dental teams during the pilot project to merely provide coverage to 11 SWD's Administrative Districts of Hong Kong (Food and Health Bureau, 2014a). On the other hand, the Government h encountered difficulty to continue and expand the pilot project due to manpower shortage. Indee NGOs had experienced difficulties in employing dentists to form outreach team (Food and Hea

Bureau of HKSAR Government, 2013) and the amount of annual subsidy to NGOs for employing a young dentist was criticised by Civil Party Legislator Dr. KWOK Ka-ki "*as far from adequate to attract dentist to join the outreach team*" (Legislative Council Secretariat, 2013b). The government still bears the operational risk which may even lead to failure of the pilot project.

Evaluation of public private partnership

The eight evaluation criteria set out in Chapter 2 are applied to assess the Pilot Project on Outreach Primary Dental Care Services for the Elderly in RCHs and DCCs.

The main objective of the project was to improve oral health of and provide primary dental care for the needy elders in RCHs and DCCs where a majority of users were frail elders or with physical difficulties to access conventional dental services. To assess the effectiveness of the project, i.e. whether the goal have been met, it is reasonably to observe the service coverage and the number of participants. By the end of the pilot project in February 2014, the 24 outreach dental teams had approached all registered RCHs and DCCs (including those operated by private organisations). The number of participating RCHs and DCCs with breakdowns in districts were as follows:

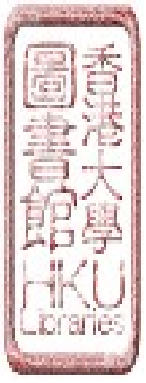


Table 7 Participation of RCHs and DCCs for the pilot project (as at end-February 2014)

SWD's Administrative District	**No. of Participating RCHs and DCCs**	**Total No. of RCHs and DCCs**	**Percentage**
Central, Western, Southern and Islands	86	97	89%
Eastern and Wan Chai	90	107	84%
Kwun Tong	43	58	74%
Wong Tai Sin and Sai Kung	45	63	41%
Kowloon City and Yau Tsim Mong	110	127	87%
Sham Shui Po	60	83	72%
Tsuen Wan and Kwai Tsing	95	103	92%
Tuen Mun	45	54	83%
Yuen Long	54	47	95%
Sha Tin	40	46	71%
Tai Po and North	73	89	82%
Total	741	894	83%

Source: Reply to independent Legislator Dr. LEUNG Ka-lau by the Government (Food and Health Bureau, 2014a)

In total, 741 RCHs and DCCs had participated in the pilot project, representing 83% of all the 894 RCHs and DCCs. Meanwhile, 62,000 elders, involving about 100,000 attendances, had been served under the pilot project (Food and Health Bureau , 2014a). With a high rate of penetration of the outreach teams, the effectiveness is considered satisfactory. Moreover, without the outrea services, elders may simply ignore their dental problems. As a consequence, their quality of life dramatically compromised.

Overall, the three-year pilot project had received positive feedback from the service users and also the participating NGOs. In this connection, the Government has converted the pilot project to a regular programme since 2014. Moreover, the scope of services in the regular programme has been further expanded to cover fillings, extractions, dentures, etc. and the recipient coverage has been extended to the elderly residing in infirmary units under the HA and nursing home registered with the DH.

As regards the efficiency, once again, we are lack of concrete data for analysis on cost and benefit. Hence, we intend to access the efficiency qualitatively. According to a reply from the Government to written question raised by the Federation of Hong Kong and Kowloon Labour Unions Legislator Mr. POON Siu-ping for the estimates of expenditure 2014-15, the total expenditure for the outreach pilot project was about $66M (up to end-February 2014) and the total attendances was about 100,000 (Food and Health Bureau, 2014b). Thus, the average cost per attendance was $660 with some attendances involving dental treatment, e.g. scaling and polishing, denture cleaning, fluoride/ X-ray, etc. By comparing with a quoted cost for replacing a missing tooth with an amount of about $2,000 by Legislator Mr. CHEUNG Man-kwong during the meeting on 10 January 2011, the average cost per dental attendance in this pilot project is relatively low. Indeed, as advised by consultant dentist of DH, primary dental check-up for the elderly on an annual basis was consider highly desirable to facilitate early detection and management of oral diseases (Legislative Coun

Secretariat, 2011). Expenses on an ounce of prevention should be lower than a pound of cure.

The provision of service was equitable. Fundamentally, the outreach dental services had been aimed at meeting the needs of the elderly with difficulties in accessing traditional dental care proactively due to their low physical mobility. Hence, systematically reduce the differences in use of dental services and enhance equal opportunity to all people in the society.

Provision of outreach dental services is an innovative service delivery mode in Hong Kong. In the initial project stage, the response of RCHs and DCCs to the outreach teams were slow possibly owing to the concerns of lack of space accommodation for operations of the team. Having strengthened the publicity with sufficient information to the staff of RCHs and DCCs and elders' family members, the Government / NGOs had given a better understanding of the services and the participating rate had gradually increased accordingly (Food and Health Bureau, 2013a). Moreover, the Government had updated the Code of Practice for Residential Care Homes requiring the attention of RCHs for the importance of oral healthcare (Legislative Council Secretariat, 2013b). The provision of services was transparent.

In respect of the stakeholders' involvement, the project had been widely consulted in LegC District Council, Elderly Commission and relevant organisations before the implementation. Duri

the planning stage, the Government had consulted potential NGOs with dental clinic and/or providing outreach dental services about their interest to participate, the required resources, funding mode, etc. The Government had also worked closely with the Hong Kong Dental Association for the pilot project details (Elderly Commission, 2011). An implementation framework was then formulated as a basic requirement for the participating NGOs to further develop their services delivery based on the characteristic of the service district(s). This approach was supported by the legislators so that funding for the pilot project was granted in 2011. During the implementation stage, experience gained and feedbacks from NGOs had been analysed and integrated. Eventually, the pilot project was converted to a regular programme in 2014 with enhancement in the amount of funding granted to NGOs, scope of services and treatment, detailed logistical support and the pool of beneficiaries (Food and Health Bureau, 2014c)

The PPP relationship between the Government and NGOs was merely fair. Although both parties had common understanding, identical objectives and clear responsibilities, two parties were only bonded by contract requirement with relationship similar to a funding and a service provider. It might be attributed to the pilot nature of the project. The Government was intending to keep the NGOs under control, and avoid deviation of service provision in which unexpected reque regarding expanding service coverage, more inclusive eligibility, etc. could be minimised during t pilot period. During a LegCo panel meeting on health services, the Government revealed that t

pilot project was an instrument to assess whether primary dental care could result to improvement of life of the elderly under current financial and manpower resources (Legislative Council Secretariat, 2011)

When it comes to the monitoring on provision of services, the Government adopted a passive approach who required the participating NGOs to keep dental records, other servicer and financial records, and submit annual reports, audited financial statements and financial reports for monitoring and auditing purpose (Food and Health Bureau, 2011). Moreover, the Government had heavily relied on statistically figures, instead of user satisfaction, to show the successfulness of the project. As mentioned before, Legislator Miss Alice MAK had urged the Government to pay attention to the service quality as she had received complaints regarding the below-standard services. Monitoring on provision of services is fair.

Overall observations

On the whole, having been evaluated under the eight evaluation criteria, the PPP of the pilot project is considered as successful. It met the profound need of the elderly residing in RCHs and DCCs with impaired physical mobility in accessing traditional dental care and at the same time broug experience to make use of the existing NGOs' service network to provide public healthcare servic

As this is a pilot project in its nature, further data collection and interim reports are needed to consolidate the success seen in the preliminary results. It would be interesting to see how PPP involving only NGOs develop and how it compares and contrasts with PPP with private providers.

Concluding Comments of Five Case Studies

The PPP in the mode of contracting out and concessions in the above studies are highly rated for which the goals can be achieved with satisfactory results. The government has conceived these PPP and made it a viable solution to solve the problem of limited resources in healthcare. For the above analysis on the PPP with the mode of contracting out, the government has carefully designed the PPP in accordance with different objectives and structures. For the hybrid mode of PPP, the government is has formulated the Ordinance for the TWGH and made the regulatory framework complete and feasible. It further designed PPP with concession for Gleneagles Hong Kong Hospital recently. In the tendering process, the first tendering was unsuccessful, this caused the government to retender and look for an appropriate private partner. This demonstrated that the government is lacking of expert in formulating contract.

All in all, all the PPP cases under analysis are successful, one of the reasons of the success because there is a well-established mechanism for scrutinizing these proposals being rolling o More PPP programmes in healthcare should be incorporated into the system with the condition th

more contract experts should be brought in. In terms of service provision, the government can address the issue the PPP of contracting out, while the financial risk is still borne by the government. In this regarding, more formations of higher level of PPP structure, such as concession, can be a solution in addressing the financing aspect of the healthcare services.

Chapter 5 Lessons, Recommendations and Conclusion

Introduction

Ageing population has been a critical issue in Hong Kong. This is not only giving pressure on elderly service provision, but also pressure on healthcare service provision. Because more elderly is directly related to more demands for healthcare services, which will definitely lengthen the waiting time for other patients at the same time.

The Harvard Report has recommended that PPP could be a way forward to address the issue of stringent healthcare resources (Food and Health Bureau, 1999). The government has initiated some pilot PPP programmes in the mode of contracting out since then. It has also further promulgated a more comprehensive mode of PPP in the approach of concession in collaboration between the private partners and the academics in the case of Gleneagles Hong Kong Hospital. The healthcare policies are ever being modified and fine-tuned. The 5 cases have been studied and evaluated against the 8 selected criteria, all of them are highly rated. The critical factors for successful PPP will be further discussed in the following sections in this Chapter.

Apart from the healthcare financing and provisions in local context will be discussed, the overse context by using the UK experiences will also be referenced in the recommendation. By usi

both the observations on local and overseas PPP and looking at the relationships to the PPP theories, final recommendations will be made.

The Key Lessons Learnt

The reports as mentioned in this paper addressed that the healthcare resources in Hong Kong was not sustainable due to consequences arising from ageing population. In addition, as the healthcare services are toll goods for which accessibility and availability must be maintained, the mentioned reports recommended to facilitate PPP in the healthcare sector. At the beginning, the PPPs in the form of contracting out for enhancing service provision were recommended.

Apart from contracting out form of PPP, the Report on First Stage of Health Reform of Food and Health Bureau (2008) also suggested pursuing PPP in hospital facilities developments for enhancing the financing side of healthcare services. It is observed that the review on Hong Kong healthcare system has never stopped and approaching a new era at every stage. The Hong Kong Government is also caution to implement each new PPP by using a pilot scheme approach.

In the analysis in the five cases in Chapter 4, the PPP in Hong Kong are highly rated. Among t PPP cases under analysis, three of them are in the form of contracting out to private partners, su as in the case of HCVS, for which the government has shifted the public to use private healthca

services by providing subsidies. In the contacting out type of PPP, the government can enhance accessibility and availability of services via 'buying' service from the private. While for the financing side, the government is stilling bearing the costs. For the TWGH case, the concession granted by the government in terms of funding arrangements has enabled the provision of service by TWGH to be sustainable in the sense that the government subsidising on healthcare for the TWGH is only for a small amount. One important aspect in the successful of TWGH PPP was the establishment of legislation which empowering it to own, invest and lease out properties. For the purpose of sustainable development in terms of financing and provision of services, concession from the government for developing hospital facilities is important in the long run.

Analysis in relation to PPP theories

By studying PPP, it was observed that shifting risks is the major considerations for the case of concession given by the government, such as the development of hospital facilities in Hong Kong. The public sector aims to shift the financial and operational risks to the private partner, the financial risk includes the cost for design and construction of the facilities, whether the project can be completed on time to provide service to the public earlier is also a major consideration.

While for the PPP in the mode of contracting out, the efficiency and effectiveness are the maj goals for which whether the capacity of the service provision can be enhanced and eventua

shorten the queue for services and shifting the public to use private healthcare resources. For the PPP in Hong Kong, the government mainly adopted demand-side interventions through contractual relationships. The public sector is still bearing most of the risks, such as contracting risk, operational risk. It is because, the public eye will still consider this is public service, the only difference is that the service is provided at private facilities.

In regard to regulatory framework, it is a tool to ensure both the public and private parties to be benefited in the relationship. In healthcare service, granting right of land use under the regulatory framework is a major concession from the government, in particular for the case in Hong Kong, where the land costs is extremely high. In the regulatory framework, it also requires flexibility in the implementation of contract in terms of monitoring, auditing, ceasing, where the scheme/programme for value-for-money must always be ensured. It is particularly valid for the PFI case in the UK with will be discussed in next section.

Recommendations

PPP are increasingly identified as an approach being capable of improving the provision and financing aspects of public healthcare. From the above lessons learnt, there are pros and cons f PPP, the following recommendations are made for the purpose of improving and strengthening t existing public healthcare provision and financing in Hong Kong.

Increase the proportion of using PPP for public healthcare services under concession

In Hong Kong, concession approach has long been existed in the form of Design-Build-operate (DBO), Build-Own-Operate-Transfer (BOOT), Build-Operate-Transfer (BOT) and Build-Own-Operate (BOO). These forms are generally regarded as Design-Build-Finance-Operate (DBFO) model, with a relatively long contract term of around 10 to 30 years, in which the outputs of the PPP facility, payment basis for the outputs and risk sharing arrangements have been specified during the contract design stage (Efficiency Unit, 2008). Indeed, TWGHs is one of the most successful cases of concession approach in healthcare system in Hong Kong with long history of providing free or affordable healthcare services. TWGHs, with legislation protection, is self-sustainable and is capable of maintaining the availability of services continuously. As the Government has just begun to bring in PPP in hybrid mode with concession and it will provide the land grant of 50 years to Gleneagles Hong Kong Hospital for design, build and operation (Legislative Council Secretariat, 2015a), reference is needed to be drawn from overseas experiences of concession for any potential deficiencies.

The UK Government reveals that the PFI can deliver good value-for-money in many aspects which include, the transfer of construction risks on delay and cost overrun; the project should be plann for a very long run instead of short term; the long period of contract facilitates the private partner procure efficiently and flexibility; enable the private to invest economically in the long run, such

equipment and staff training; the private partner could further transfer the risks to sub-contractor; contract was continuously monitored ensuring value-for-money (European Union, 2013).

Although there are pros for PPP in the UK PFI, it is recommended to develop the concession approach in PPP for various public healthcare services with enhanced contract clauses to avoid financial loss of the government. Enhancement works can be achieved by improving the flexibility of the contract and supplementing negotiating clauses under prevailing conditions which avoids a hold-up situation as mentioned. Moreover, a higher degree of concession to the PPP in return of shifting more risks to private partners should also be considered after having balanced the public interests and private benefits.

Bring in more experts for contract design

As mentioned before, PPP in concession mode is not uncommon in Hong Kong. It occurs mostly in construction works projects requiring private sectors to design, build and operate. No matter the form of services is, contract designer is of prime importance for drafting a contract with balanced public interests and private benefits. By drawing up specifications of output and/or outcome, setting standards of performance and providing advice on particular practice on a services or worl expertise in contract design of PPP in public healthcare services could definitely improve t sustainability of the required services.

When referencing the PFI experiences in UK, although experiences from the UK shows that using of concession in PFI mode, that is the Design-Build-Finance-Operate mode of PPP (Ho & Tsui, 2009) contract, could deliver good value for money to public sector, there are criticisms of the non-self-sustainable of PFIs and the procuring authority might not be able to optimise the benefits (Legislative Council Secretariat, 2005).

In a PFI project of UK, building firms and developers will be invited to invest in the design, build, finance, operate the project and they will then lease them back for a very long period of time, usually 25-30 years. The repayments from the NHS throughout the period are usually at a high rate of interest. This means that the debts will be repaid by future taxpayers (Telegraph, 2011). According to the same report, some hospitals have attempted to exit from their PFI contracts due to financial difficulties, however, since these PFIs are too big to fail and the government was forced to bail out struggling trusts. According to Financial Times, the UK Department of Health gave bailouts of £1.5bn to seven trusts of PFIs, which shows that PFI itself is not self-sustainable with need the injection of money from the public (Plimmer & Neville, 2014).

The Hong Kong government must reference on the deficiencies of UK PFI as mentioned. Accordi to the introductory guide to PPP issued by Efficiency Unit (2008), outside advisors, w

commercial perspectives and experience, are recommended to be appointed by the government to provide a wider range of skills to the public sector in formulating and delivering PPP contracts. Due to the insufficient PPP related experience and expertise of public sector, government departments are also advised to address this skill deficit problem by employing such technical consultant and then transferring the skills to in-house workforce. Although the Hong Kong Government has observed the potential deficiencies and provides guidelines, the more important part of making the PPP successful is that the procuring departments can strictly adhere to the guidelines.

Formulate complete guidelines setting up PPP contract

A successful PPP contract may involve shifting of risks, formulating of regulatory framework, maintaining flexibility of contract and achieving high effectiveness. Indeed, the procedures in formulating and delivering PPP contracts are complicated which requires highly experienced and expertised personnel. Therefore, the provision of PPP guidelines with steps by steps procedures could definitely promote future success of the PPP and strike a balance between the public and private sectors for a win-win situation.

The introductory guide to PPPs issued by Efficiency Unit is a PPP guideline with the first a second editions issued in August 2003 and March 2008 respectively. To meet the changi environment, adjustment to the guideline in a regular period is required. Moreover, guideline ir

more compatible way to both works and non-works related PPP should be offered.

Monitoring of private partners

Proper monitoring of private partners enables the private partner to be more accountable and hence improves the provision and financing of healthcare services and ensures value for money. Under the PPP contract, suitable performance indicators should be set up. Monitoring of performance in the form of regular checks, spot checks and audit are traditional and practical method which are indispensable and are able to enhance the transparency of PPP.

In the UK PFI experience, according to Telegraph (2011), private contractors under PFI arrangements have very high profit margins, for example, there was a job in the hospital which charged £52,000 by the private contractor that costs only £750. The UK Government was advised have more experts in contract negotiation which avoiding formulating a PFI arrangement in favour of private investor (Telegraph, 2011). In the press report of Telegraph in 2011, the National Audit Officer of UK had reported that the UK Government should have more power to cancel or renegotiate the terms on an existing PFI which ensuring the PFI is value for money.

Licensing for services provided by the private partners is one of the monitoring tools in the PI Therefore, it is recommended to issue licenses to private partner to provide the service. Indee

license renewal/ revocation is capable of providing an additional opportunity to monitor performance of private partners which aiming at ensuring service quality.

Conclusions

The government of Hong Kong has put a lot of efforts on the reform on healthcare system for maintaining its sustainability under limited resources. For more than 100 years ago, the government of Hong Kong has already begun adapting collaboration between the public and private sectors with the provision of Law which enabling the TWGH to be sustainable financially. To go further, the government has initiated studies on the healthcare reform and the future of Hong Kong healthcare in terms of financing and provision, such as the studies in the Scott Report in 1985, Rainbow Document in 1993, Harvard Report in 1997, second Harvard Report in 1999 and official healthcare reform document in 2008. The reviews on Hong Kong healthcare system by the government has never stopped. The government has acknowledged the need of forming PPP for solving the problem of public healthcare resources constraints and has taken steps to formalise and strengthen the concept of PPP into action.

.

Based on the evaluation against criteria (i.e. effectiveness; efficiency; due process; regulato framework and flexibility and collaborative relationships) for the PPP in the five real cases of P in healthcare in Hong Kong, it is confirmed that PPPs in healthcare in Hong Kong are ve

successful yet potential deficiencies still exist. On the other hand, for the UK experiences of PFI, the deficiencies in flexibility on contract design causes the PPP to be difficult to sustain financially and monitoring capability of government was also in doubt.

In the long run, the government is obliged to properly formulate regulatory framework to facilitate the formations of PPP relationships with the best interests for both public and private partners, in particularly for a higher level collaboration with the mode of concession. This is not only addressing the provision constraint, but also shifting lots of financial risks to the private partners. Besides maintain flexibility of contract on monitoring of performances of private partner, or even the ceasing clauses to be included which avoiding the hold-up problem with high transaction costs is also of utmost importance for ensuring the PPP is value-for-money.

In a well-developed city like Hong Kong, healthcare service is ever getting better day by day, the life expectancy of Hong Kong people is also getting longer. Without a sustainable mode of healthcare provision and financing, the healthcare expenditure will become a serious burden in the future, which eventually affects the developments in other areas in Hong Kong. The study of PPP in this paper with positive recommendations is a step forward for addressing the issues for now and f the future of Hong Kong.

References

Axelsson Runo and Axelsson Susanna Bihari.(2006) Integration and collaboration in public healthation and collaboration.*The International Journal of Health Planning and Management* (2006; 21: 75; te)

Asian Development Bank. (2016). *Public-Private Partnership Handbook*. Asian Development Bank. Retrieved from http://www.adb.org/documents/public-private-partnership-ppp-handbook

Audit Commission, HKSAR. (2014). Provision of health services for the elderly. *Report No. 63 of the Director of Audit, Chapter 2, 36-59.* Retrieved on 26 May 2016 from http://www.aud.gov.hk/pdf_e/e63ch02.pdf

Baldwin, R, Cave., & Lodge, M. (2012). *Understanding regulations: Theory, strategy, and practice*. New York: Oxford University Press.

Blaikie, P. (1985). *The Political Economy of Soil Erosion in Developing Countries*. London: Longman.

Blanken, A., & Dewulf, G. (2010). PPPs in health: static or dynamic? *Australian Journal of Public Administration, 69*(s1), S35-S47.

Buse, K., & Walt, G. (2000). *Global public-private partnerships: part I - A new development in* health? *Bulletin of the World Health Organization*, 78(4), 549-561.

Bolland JM & Wilson JV. (1994). Three faces of integrative coordination: a model of interorganizational relations in community-based health and human services. *Health Service Research* 29: 341–366.

Bullard, R.D. (1990). *Dumping in Dixie: Race, Class, and Environmental Quality*. Boulder: Westview Press.

Canadian Council for Public-Private Partnerships. (2011). *Public-private Partnerships – a Gui for Municipalities.* Retrieved fr http://www.p3canada.ca/~/media/english/resources-library/files/p3%20guide%20for%20 unicipalities.pdf

Census and Statistics Department, HKSAR. (2015). *Hong Kong Population Projections 2015-2064.* Retrieved on 26 May 2016 from http://www.statistics.gov.hk/pub/B1120015062015XXXXB0100.pdf

Central Intelligence Agency, USA. (2015). *World Fact Book*. Retrieved on 7 June 2016 from https://www.cia.gov/library/publications/the-world-factbook/

Chapman, J. L., et al. (2004). Systematic Review of Recent Innovations in Service Provision to Improve Access to Primary Care. British Journal of General Practice 54(502):374–81.

Cheung CF, Moy P, Ng KC (2012). "Bidders running shy of hospital tender demands". South China Morning Post (Hong Kong), on 13 Mar 2013

Cheung E. (2015, November 13). Hong Kong elderly shy away from using government vouchers for body checks. *South China Morning Post.* Retrieved on 12 April 2016 from http://www.scmp.com/news/hong-kong/health-environment/article/1878243/hong-kong-elderly-shy-away-using-government.

Davis, G., & Ostrom, E. (1991). A Public Economy Approach to Education: Choice and Co-Production. *International Political Science Review*, 12(4), 313-335.

Department of Health, HKSAR. (2011). *Oral Health Survey 2011*. HKSAR Government. Retrieved on 10 June 2016 from http://www.toothclub.gov.hk/en/en_pdf/Oral_Health_Survey_2011/Oral_Health_Survey_2011_WCAG_20141112_(EN_Full).pdf

Department of Health, HKSAR. (2016). HealthyHK, *Infant Mortality Rate*. Retrieved on 7 June 2016 from http://www.healthyhk.gov.hk/phisweb/en/healthy_facts/health_indicators/infant_mortality_rate/

Efficiency Unit, HKSAR. (2008). *An Introductory Guide to Public Private Partnerships (PPPs)*. March 2008 (2nd ed.). Retrieved on 1 July 2016 from http://www.eu.gov.hk/en/reference/publications/ppp_guide_2008.pdf

Elderly Commission, HKSAR. (2011). *Elderly Commission Minutes of the 65th Meeting held on January 2011*. Retrieved on 8 June 2016 from http://www.elderlycommission.gov.hk/en/meeting/Min-65e.pdf

European Union. (2013). *Health and Economics Analysis for an evaluation of the Public Private Partnerships in healthcare delivery across EU.* European Union. Retrieved from http://ec.europa.eu/health/expert_panel/documents/publications/docs/ppp_finalreport_en.pdf

Food and Health Bureau. HKSAR. (1999). *Improving Hong Kong's Healthcare System : Why and For Whom? by Havard Team.* Retrieved from http://www.fhb.gov.hk/en/press_and_publications/consultation/HCS.HTM

Food and Health Bureau, HKSAR. (2008). Report on First Stage of Health Reform. HKSAR Government Logistics Department. Retrieved from http://www.fhb.gov.hk/beStrong/eng/consultation/consultation_report1.html

Food and Health Bureau, HKSAR. (2011a). *Interim Review of Elderly Health Care Voucher Pilot Scheme.* Retrieved from on 26 May 2016 http://www.hcv.gov.hk/files/pdf/ehcv_interim_review_report_en.pdf

Food and Health Bureau, HKSAR. (2011b). Legislative Council Panel on Health Services - Pilot Project on Outreach Primary Dental Care Services for the Elderly in Residential Care Homes and Day Care Centres. Retrieved on 4 June 2016 from http://www.legco.gov.hk/yr10-11/english/panels/hs/papers/hs0110cb2-729-3-e.pdf

Food and Health Bureau, HKSAR. (2012). Administration's response on pilot project on outreach primary dental care services for elderly in residential care homes and day care centres. Retrieved on 4 June 2016 from http://www.legco.gov.hk/yr10-11/english/panels/hs/papers/hs0110cb2-1185-1-e.pdf

Food and Health Bureau, HKSAR. (2013a). Legislative Council Panel on Health Services - Dental Care Policy and Pilot Project on Outreach Primary Dental Care Services for the Elderly in Residential Care Homes and Day Care Centres. Retrieved on 4 June 2016 from http://www.legco.gov.hk/yr12-13/english/panels/hs/papers/hs0617cb2-1315-5-e.pdf

Food and Health Bureau, HKSAR. (2013b). *Replies to Legco Question 10 on Elderly Health Ca Voucher Scheme*. Retrieved on 26 May 2016 from http://www.fhb.gov.hk/en/legco/replies/2013/lq130220_q10.htm

Food and Health Bureau, HKSAR. (2014a). Replies to initial written questions raised by Finance Committee Members in examining the Estimates of Expenditure 2014-15 Reply Serial No. FHB(H)130. Retrieved on 5 June 2016 from http://www.fhb.gov.hk/download/legco/replies/140404_sfc/e-fhb-h.pdf

Food and Health Bureau, HKSAR. (2014b). Replies to initial written questions raised by Finance Committee Members in examining the Estimates of Expenditure 2014-15 Reply Serial No. FHB(H)247. Retrieved on 5 June 2016 from http://www.fhb.gov.hk/download/legco/replies/140404_sfc/e-fhb-h.pdf

Food and Health Bureau, HKSAR. (2014c). Legislative Council Panel on Welfare Services. Support for Elderly Persons who are in Need of Dental Care. Retrieved on 5 June 2016 from http://www.legco.gov.hk/yr13-14/english/panels/ws/papers/ws0630cb2-1900-1-e.pdf

Food and Health Bureau, HKSAR. (2014d). *Consultation Document on Voluntary Health Insurance Scheme.* Retrieved on 26 May 2016 from http://www.vhis.gov.hk/doc/en/full_consultation_document/consultation_full_eng.pdf

Food and Health Bureau, HKSAR. (2015a). *Replies to Legco Question 18 on Elderly Health Care Voucher Scheme*. Retrieved on 26 May 2016 from http://www.info.gov.hk/gia/general/201506/17/P201506170716.htm

Food and Health Bureau, HKSAR. (2015b). *Legislative Council Panel on Health Services - Update on the Implementation of the Elderly Health Care Voucher Scheme.* Retrieved on 26 May 2016 from http://www.legco.gov.hk/yr15-16/english/panels/hs/papers/hs20151116cb2-235-8-e.pdf

Food and Health Bureau, HKSAR. (2015c). *Report of the Steering Committee on Review of Hospital Authority*. HKSAR Government Logistics Department. Retrieved from http://www.fhb.gov.hk/en/committees/harsc/report.html

Food and Health Bureau, HKSAR. (2016a). *Hong Kong Domestic Health Account 2010/11*. Retrieved on 7 June 2016 from http://www.fhb.gov.hk/statistics/en/dha.htm

Food and Health Bureau, HKSAR. (2016b). *Replies to Legco Question 1 on Elderly Health Ca Voucher Scheme*. Retrieved on 26 May 2016 from http://www.fhb.gov.hk/en/legco/replies/2016/lq160518_q01.htm

Food and Health Bureau, HKSAR (2016c). *Total expenditure on health (TEH) as % of GDP.* Retrieved on 7 June 2016 from http://www.fhb.gov.hk/statistics/en/statistics/health_expenditure.htm

Foucault, M. (1978). *Right of Death and Power over Life. From The History of Sexuality, Volume1: An Introduction, translated by Robert Hurley and excerpted in The Foucault Reader, edited by P. Rabinow* [New York: Pantheon, 1984]

Gleneagles Hong Kong Hospital. (2016). Retrieved on 7 June 2016 from http://www.gleneagles.hk/about-gleneagles-hong-kong-hospital/

Glendinning C. (2003) Breaking down barriers: integrating health and care services for older people in England. *Health Policy* 65: 139–151.

Gould, D.B. (2001) Healthcare Reform in Hong Kong, *Hong Kong Medical Journal*, v. 7 n. 2, 150-154. Retrieved on 21 July 2016 from http://www.hkmj.org/system/files/hkm0106p150.pdf

Gulliford, M., Figueroa-Munoz, J., Morgan, M., et al. (2002). What Does 'Access to Healthcare' Mean? Journal of Health Services Research and Policy 7(3):186–8

Health Canada. (1999). Intersectoral Action Towards Population Health. Report of the Federal/ Provincial/Territorial Advisory Committee on Population Health. *Health Canada Publications: Ottawa.*

Hedley, A.J. (2001). Healthcare Reform in Hong Kong, *Hong Kong Medical Journal*, v. 7 n. 2, 116-117

Hellowell, M., & Pollock, A. M. (2009). The private financing of NHS hospitals: politics, policy and practice. *Economic Affairs*, *29*(1), 13-19.

HKU. (2016). Tung Wah Hospital Ordinance Chapter 317, *HKU Historical Laws of Hong Ko Online.* Retrieved from http://oelawhk.lib.hku.hk/items/show/2171

Ho, S. P., & Tsui, C. W. (2009, November). The transaction costs of Public-Private Partnershi implications on PPP governance design. In *Lead 2009 Specialty Conference: Glob Governance in Project Organizations, South Lake Tahoe, CA* (pp. 5-7).s

Hong Kong Law, HKSAR. (1971). *Tung Wah Group of Hospitals Ordinance. Chapter 1051*.

Hospital Authority, HKSAR. (2007). *Additional Cataract Surgeries Programme* (AOM\PAPER\516). Retrieved from http://www.ha.org.hk/haho/ho/cad_bnc/133820e.pdf

Hospital Authority, HKSAR. (2013a). *Hospital-based Patient Experience and Satisfaction Survey*. Hospital Authority. Retrieved from http://www.ha.org.hk/haho/ho/cad_bnc/HAB_P211.pdf

Hospital Authority, Food and Health Bureau, HKSAR. (2013b). *Provision of Cataract Surgeries in Hospital Authority* (LC Paper No. CB(2)1531/12-13(01)) Retrieved from http://www.legco.gov.hk/yr12-13/english/panels/hs/papers/hscb2-1531-1-e.pdf

Hospital Authority, HKSAR. (2014a). *Patient Experience and Satisfaction Survey on Specialist Outpatient Service*. Hospital Authority. Retrieved from https://www.ha.org.hk/haho/ho/cad_bnc/HAB-P227.pdf

Hospital Authority, HKSAR. (2015a). *Implementation of the Recommendations of the Steering Committee on Review of Hospital Authority*. Retrieved from http://www.ha.org.hk/haho/ho/cc/HA_Review_Action_Plan_Final_en.pdf

Hospital Authority, HKSAR. (2015b). *Annual Report 2014-15*. Hospital Authority: Retrieved from http://www.ha.org.hk/ho/corpcomm/AR201415/PDF/HA_AnnualReport2014-15_FINAL.pdf

Hospital Authority, HKSAR. (2016). *Waiting Time for Cataract Surgery.* Retrieved from https://www.ha.org.hk/visitor/ha_visitor_text_index.asp?Parent_ID=214172&Content_ID=214184

Information Services Department, HKSAR. (2013). Hong Kong Government Press Release. Retrieved from http://www.info.gov.hk/gia/general/201303/13/P201303130390.htm

Information Services Department, HKSAR. (2016). Incubator incident probed. Informati Services Department Website. Retrieved frc http://www.news.gov.hk/en/categories/health/html/2016/05/20160522_191658.shtml

Khan, A. A., and Bhardwaj, S. M. (1994). Access to Healthcare. A Conceptual Framework and Relevance to Healthcare Planning. Evaluation and the Health Professions 17(1):60–76.

Kickbusch, I., & Quick, J. (1998). Partnerships for health in the 21st century. *World health statistics quarterly. Rapport trimestriel de statistiques sanitaires mondiales, 51*(1), 68-74.

Koppenjan, J. J. F. M. (2005). The Formation of Public-Private Partnerships: Lessons from Nine Transport Infrastructure Projects in The Netherlands. *Public Administration, 83*(1), 135-157.

Legislative Council Secretariat. HKSAR (1995). *Hansard Sitting.* Retrieved from http://www.legco.gov.hk/yr95-96/english/lc_sitg/hansard/han2510.htm#E84E14

Legislative Council Secretariat. HKSAR (2005). *Public Private Partnerships*. Retrieved from http://www.legco.gov.hk/yr04-05/english/sec/library/0405rp03e.pdf

Legislative Council Secretariat, HKSAR. (2011). *Legislative Council Panel on Health Services - Minutes of meeting held on 10 January 2011*. Retrieved on 7 June 2016 from http://www.legco.gov.hk/yr10-11/english/panels/hs/minutes/hs20110110.pdf

Legislative Council Secretariat, HKSAR. (2013a). *Legislative Council Panel on Health Services - Background brief prepared by the Legislative Council Secretariat for the meeting on 17 June 2013 Dental Care Policy and Pilot Project on Outreach Primary Dental Care Services for the Elderly in Residential Care Homes and Day Care Centres.* Retrieved on 4 June 2016 from http://www.legco.gov.hk/yr12-13/english/panels/hs/papers/hs0617cb2-1315-6-e.pdf

Legislative Council Secretariat, HKSAR. (2013b). *Legislative Council Panel on Health Services - Minutes of meeting held on 17 June 2013.* Retrieved on 4 June 2016 from http://www.legco.gov.hk/yr12-13/english/panels/hs/minutes/hs20130617.pdf

Legislative Council Secretariat, HKSAR. (2015a). *Updated background brief prepared by the Legislative Council Secretariat for the meeting on 16 March 2015 on Private hospital development.* (LC Paper No. CB(2)993/14-15(04)). Retrieved from http://www.legco.gov.hk/yr14-15/english/panels/hs/papers/hs20150316cb2-993-4-e.pdf

Legislative Council Secretariat, HKSAR. (2015b). *Legislative Council Panel on Health Servic Background brief prepared by the Legislative Council Secretariat for the meeting on November 2015 on Elderly Health Care Voucher Scheme.* Retrieved on 26 May 2016 fro http://www.legco.gov.hk/yr15-16/english/panels/hs/papers/hs20151116cb2-235-9-e.pdf

Lieu, G. (2004) *The Hong Kong's Healthcare Reform in Past Two Decades,* The Institute for Health Policy & Systems Research. Retrieved on 7 June 2016 from http://www.ihpsr.org.hk/uploads/files/2015/Lieu_APACHS_2004.pdf

Lu W. & Edney A. (2014, September 18) Where Do You Get the Most for Your Healthcare Dollar? *Bloomberg*. Retrieved from http://www.bloomberg.com/infographics/2014-09-15/most-efficient-health-care-around-the-world.html

Mitchell, M. (2008). An overview of public private partnerships in health. *International Health Systems Program Publication, Harvard School of Public Health*. Retrieved on 12 January 2016 from https://www.hsph.harvard.edu/ihsg/publications/pdf/PPP-final-MDM.pdf

Ng, YH, Lee, E (2010). "Government gets 30 applicants for private hospitals". South China Morning Post (Hong Kong) on 1 April 2010

Nikolic, I. A., & Maikisch, H. (2006). Public-private partnerships and collaboration in the health sector. *An overview with case studies from recent European experience*. Retrieved on 26 May 2016 from http://ps4h.org/docs11_ppp/Nikolic%20PPP.pdf

Ostrom, V, and Ostrom, E. (1991). "Public Goods and Public Choices: The Emergence of Public Economies and Industry Structures." *In The Meaning of American Federalism*, ed. Vincent Ostrom, 163-97. San Francisco, CA: Institute for Contemporary Studies Press.

Parker, A. W. (1974). The dimension of Primary Care: Blueprint for change. In S. Andreopoulos, Primary Care: Where Medicine Fails (pp. 15-77). New York: Wiley.

Parliament of Canada. (2001). *Public and Private Sector Involvement in Healthcare Systems: A Comparison of OECD Countries*. Government of Canada Publications. Retrieved from http://publications.gc.ca/Collection-R/LoPBdP/BP/bp438-e.htm#INTRODUCTIONTXT

Peluso, N.L. & P. Vandergeest. (2001). "Genealogies of Forest Law and Customary Rights Indonesia, Malaysia, and Thailand." *Journal of Asian Studies 60:761–812*.

Plimmer G. & Neville S. (2014, October 1). NHS trust becomes first to buy out its PFI contract. *Financial Times.* Retrieved from http://www.ft.com/cms/s/0/cc4f10b2-4951-11e4-8d68-00144feab7de.html#axzz4F3BgIk E

Pongsiri, N. (2002). Regulation and public-private partnerships. *International Journal of Public Sector Management*, *15*(6), 487-495.

Ribot, J.C., Peluso, N.L. (2003). A Theory of Access. *Rural Sociology Society,* 68(2), pp. 153–181.

Roehrich Jens K., Lewis Michael A. & George Gerard. (2014) Are public-private partnerships a healthy option? A systematic literature review. *Social Science & Medicine 113 (2014) 110e119*

Rogers, A., Flowers, J., and Pencheon, D. (1999). Improving Access Needs a Whole Systems Approach. And Will Be Important in Averting Crises in the Millennium Winter. British Medical Journal 319(7214):866–7.

RUPRI (2014). Access to Rural Healthcare – A Literature Review and New Synthesis. RUPRI Panel. Retrived from http://www.rupri.org/Forms/HealthPanel_Access_August2014.pdf

Salamon, L. M. (2002). The Tools of Government: A Guide to the New Governance. New York: Oxford University Press.

Shipton, P. & Goheen, M. (1992). "Understanding African Landholding: Power, Wealth and Meaning." Africa 62:307–27.

Singh, A., & Prakash, G. (2010). Public–private partnerships in health services delivery: a network organizations perspective. *Public Management Review*,*12*(6), 829-856.

Telegraph. (2011, September 20). Private Finance Initiative: where did all go wrong? Telegraph Media Group Limited Retrieved from http://www.telegraph.co.uk/news/health/news/8779598/Private-Finance-Initiative-where-did-all-go-wrong.html

The World Bank. (2012). *Public-private Partnerships e Reference Guide Version 1.0.* International Bank for Reconstruction and Development/International Development Association or The World Bank, Washington, D.C., USA. Retrieved fr http://www.ppiaf.org/sites/ppiaf.org/files/publication/Public-Private-Partnerships-Referer e-Guide.pdf

The World Bank (2016) *Life Expectancy at Birth.* Retrieved on 7 June 2016 fr http://data.worldbank.org/indicator/SP.DYN.LE00.IN

Torchia, M., Calabrò, A., & Morner, M. (2015). Public–private partnerships in the healthcare sector: A systematic review of the literature. *Public Management Review*, *17*(2), 236-261. doi:10.1080/14719037.2013.792380

Thynne, I., & Peters, B. G. (2015). Addressing the Present and the Future in Government and Governance: Three approaches to Organising Public Action. *Public Admin. Dev. Public Administration and Development*, 35(2), 73-85.

Tung Wah Group Hospitals (TWGH). (2016). Annual Report 2015-16. Tung Wah Group Hospitals. Retrieved from http://www.tungwah.org.hk/en/media/publications/annual-report/annual-report-20152016/

UK Office of National Statistics (2015). Expenditure on Healthcare in the UK: 2013. UK Office of National Statistics. Retrieved from http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/expenditureonhealthcareintheuk/2015-03-26

UK Trade and Investment & UK Department of Health. (2013). *Healthcare UK: Public Private Partnerships*. UK Trade and Investment. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266818/07_PPP_28.11.13.pdf

United Nations. (2015). *Life Expectancy at Birth*. Retrieved on 7 June 2016 from http://data.un.org/Data.aspx?d=PopDiv&f=variableID%3A68

Vangen S. & Huxham C. (2003) Nurturing collaborative relations: building trust in interorganizational collaboration. *Journal of Applied Behavioral Science*, 39(1) pp. 5–31.

Vedung, E. (2006). Evaluation Research. In B. G. Peters and J. Pierre (Eds.), *Handbook of Public Policy*, (pp. 397–416). London: SAGE.

Wong, L (1993). “Go ahead for hi-tech hospitals”. South China Morning Post (Hong Kong), on 22 Jun 1993

Wong, E.L.Y., Yeoh, E.K., Chau, P.Y.K., Yam, C.H.K., Cheung, A.W.L. & Fung H. (2015). How shall we examine and learn about public-private partnerships (PPPs) in the health sector? Realist evaluation of PPPs in Hong Kong, *Social Science and Medicine*, 147, 261-269