Hong Kong Society of
Health Service Executives
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Editorial

Beyond Disease and Treatment Toward Health and Well Being

I came across an interesting article recently on "Beyond Money, Toward an Economy of Well Being" published in the American Journal of Psychology and written by two very prominent professors in psychology. The authors argued that organizations and countries should be more heavily influenced by well being than by economic indicators. In essence, the starting point should not be money, even though for centuries, we have assumed that money increases well being. The starting point should be focused on increasing each individual's well being and there is no better place to start than to begin at home.

Individuals with high well being enjoy better health, are happier workers, more productive at work, make more money, socialize more and lead a happier family life. Individuals with high well being score better on all fronts and despite the fact that economics may have a part to play in increasing the well being of an individual by meeting their most basic needs, the effects of wealth are not large and can be dwarfed by many factors.

So what does this mean to the health service executives of the twenty first century? Perhaps we can take the message and ask several questions. Firstly, how can we ensure that our workforce consists of high well being individuals? Can we find such people to fill the vacancies in our workplace? More importantly, how can we measure our staff's well being and provide a work environment that increases their level of well being. This is important, as we all know that there can be spillover effect. If our staffs enjoy their work, accumulates a high level of well being, they can spill over the effect to their family and in turn the entire society benefits.

Secondly, we must help to change the paradigm of our health care system towards a health and well being oriented model rather than a disease and treatment oriented one. And finally, we must not only find ways to measure well being but help our patients improve their well- being. A nation with lots of high well being individuals is a happy nation and it is not unrealistic to think that this can be achieved. From healing individuals to producing well being, are we ready to face this challenge?

As this is the last issue of the Society's newsletter, may I take this opportunity to thank all who have supported my work in bringing to reality the Society's Newsletter. I am especially grateful to members of the Editorial Board and to those who have contributed articles, photos and ideas.

Margaret Tay
Publication Covenor ■

Message from the Chairman

The health Care reform conundrum has recently attracted much lime light in the HKSAR after the Hospital Authority (HA) Chief Executive publicly warned about the risk of service quality deterioration in the coming few years if the rapidly growing budget deficit was left unattended. In response to this alarm, a series of newspaper editorials, documentaries and columnist comments cropped up with grossly divergent views. The only consensus seems to be that the existing system is not sustainable in the long run, and prompt actions should be taken to address this issue before it is too late.

Some newspaper editorials considered the "oversized and inefficient management structure" of HA the sole culprit of its financial predicaments, and called for major trimming to make available enough resources to address the budget deficit. However, according to the data presented by HA, administration and management staff cost constituted only 1% of its total expenditure, and even total elimination of this staff group could not save enough money to fill the budget gap.

Others contended with the notion that the existing level of spending in healthcare in terms of GDP percentage is too low with reference to the degree of population ageing, level of technology/expertise and public expectation of Hong Kong, notwithstanding some doubt on the accuracy of the figure when one-off expenditures for land and facility buildings were excluded. But there is no agreement regarding the payer(s) of the additional money, the manner of spreading the burden across the whole society, and the role played by the government on this issue. Even more controversial is the optimal level of GDP percentage that should be spent in healthcare. Economic theories state that the optimal point is reached when the additional marginal resource produces same marginal utility in healthcare when compared to other areas of spending. But how to compare the marginal utility produced by investing in healthcare with that of education or security is another challenge.

There is also a widely shared view that by limiting access to public healthcare through some form of rationing, those with means will be forced to seek care from the private sector, thus reducing the so-called "public-private imbalance". At the same time the budget deficit of HA can also be ameliorated. While the actual financial impact of this approach needs further study, it must be reminded that with the existing triage system adopted by HA, patients are assessed according to the level of treatment urgency, not their affordability to private sector service. As a consequence, patients with serious diseases are given priority even if they can afford the private system, while poor patients will be denied reasonable access to necessary health problems that are not imminently life or limb-threatening. And when these underprivileged patients' conditions worsen to a critical stage, they will be admitted into the public system through A&E as the last resort. I am not sure if this is a good example of "target subsidy" as advocated by Government officials, but it seems to contravene the newly defined mission of HA to provide appropriate care for the poor. On the other hand it will be impractical to ask clinical staff to act as means assessor for every patient coming under their care.

Adding complexity to the picture is the fact that there are many stakeholders having conflicting interests. The expectations of the middle class people are different from that of the lower social classes. Even the "private sector" is multipartite in its constituency, with private hospital boards, solo private practitioners, physician groups, healthcare plan providers, pharmaceutical companies, community pharmacies and healthcare insurers all holding different stakes. It would be impossible to design a system that can please every party. But how to compare the concerns of different stakeholders and come up with the most satisfying or least dissatisfying proposal will require the wits of a genius. Maybe a good starting point is to build healthcare economic models for scenarios of different combinations of healthcare delivery systems and financing methods. So far such models are lacking, and most arguments are based on piecemeal data, intuition and personal experience.

So what should a health service executive do at this juncture of uncertainty and imminent system revamp? Other than participating in the debate and making proposals, I think there are still many things we should and can do which are independent of the financing arrangement or delivery model. Firstly we should continue with our effort of making the healthcare environment safe for both staff and patients. Secondly we should try to maximize the productivity and efficiency of the system given the existing healthcare system. We should minimize wastage of scarce resources and time. Thirdly we should ensure effectiveness of our care for patients, and there should be appropriate adoption of available and reliable evidences. Fourthly we should try to cultivate cohesive work team and maintain high morale among the workforce. That will demand good leadership from the executives. Lastly, we should continue with the effort of developing competitive human capital through staff training and coaching, with the goal of fostering a spirit of continuously learning within the organization. With these efforts, we will be able to better prepare ourselves for the challenges to come.

Dr MA Hok-cheung ■

Postscript

I was reminded by our Publication Convenor that this will be the last issue of Society newsletter, because there is a plan to wind up the society and to put all its activities and functions under the newly established Hong Kong College of Health Service Executives. For this reason I would like to mention some more points.

The inauguration ceremony of the College was successfully held on the 20th May 2005, after much sweat and heartburns. I am glad to say that we have gathered 60 founding fellows and two honorary fellows to embark on the journey of making the College an icon of health service management in Hong Kong. We hope the College will serve as a common platform for executives of both public and private sectors to share views and practices and to foster more intimate networking and collaboration. The College will also strive to maintain close relationship with the Hong Kong College of Community Medicine and the Australian College of Health Service Executives. There is also a vision to broaden our connection with other organizations and professional bodies with similar missions and purposes in the Asia-Pacific region as well as Mainland China. But the most important message is that we would like to see all the existing members of the Society joining the College as associates and associate fellows, and actively participating in its activities and functions. The College will have its own regular publications, and we look forward to seeing more input from members and fellows related to common concerns in health care and matters of major public interest.

Knowledge Management and Evidence-based Practice

- Implications for Health Services Management

Abstract:

In the new information eco-system, there are too much data and information. Value is added in the data-information-knowledge chain by filtering, critically appraising the information and applying to practice. The author draws an analogy from the literature on knowledge management and evidence-based practice and highlights the importance of adding value to the process of the transformation of data to information, and from information to knowledge for evidence-based practice, not only from the individual practitioner's point of view, but also from the organizational perspective.

"We live in proportion to our ability to respond to and correlate ourselves with our environment.. .. Today the only thing that is permanent is change … So rapid has been this advance (in medicine), as new knowledge developed, that the truth of each year was necessarily modified by new evidence, making the truth an ever-changing factor." …. Sir Charles Horace Mayo, Dr (1931)

Changes and challenges facing today's health care managers are many: the information explosion, changing knowledge paradigms, and consumer empowerment are just a few of them. The new environment calls for new ways of coping with and managing knowledge at the individual, organizational and the community levels.

This article examines the principles and tools of knowledge management (KM) and highlights some examples how they can be incorporated to evidence-based practice (EBP) of individual practitioners and healthcare organizations. Unless organizations can identify and capture the knowledge they have, they would find it hard to re-use, adapt and innovate effectively.

Evidence-based Practice in Health Care

Since the early 1990's, a number of important concerns emerged. In a review of 45,000 biomedical papers published between 1950 and 1978, many research studies (80%) were found to be deficient in methodologic rigour (Policy Research Incorporated 1979). There was also a crisis of confidence concerning the quality control of published papers and the prevalence of scientific fraud (Silverman WA 1998, 27). Combined with the sheer volume of literature, it is very hard to keep up-to-date using the traditional approach of continuous professional education.

In response, there has been increasing focus on EBP in health care. Evidence-based medicine is defined as "the integration of current best evidence, clinical expertise and patient values in making decisions about the care of individual patients." (Sackett et al 2000). Evidence-based practitioners ask why certain health care interventions are being done (or not done), and produce quantitative estimates of effectiveness (or limitations) to justify them.

Despite the large volume of publications in medical literature in journals as well as on the Internet, not many of them (about 1 percent) were judged to have met the criteria for best evidence. The general findings of many studies were that only a small number of studies available on the Web followed guidelines for treatment recommended by national professional bodies (Impicciatore P, Pandolfini C, Casella N, Bonati M 1997; McClung H, Juhling MD, Murray RD, Heitlinger LA 1998).

Thus there is a need to apply filters in searching, and to critically appraise clinical literature in order to make judgement about its validity and relevance in clinical practice (Naylor and Guyatt 1996). From the individual perspective, EBP approach keep clinicians up-to-date with new clinical knowledge and improve patient outcomes. From the population perspective (organizational/meso- level), EBP advocates believe that the method will facilitate quality care and risk management, the provision of ethical and equitable service, and the efficient & effective distribution of scarce resources.

Need for Knowledge Management in Healthcare

The geometric growth in medical knowledge and increasing specialisation in medicine mean that disease management and the care of patients increasingly require expertise and sharing of knowledge across disciplines.

With the explosion of electronic publishing and its wide and easy availability to the layman, patients often make reference to materials published on the Internet. Patients' own perceptions, values, preferences and demands, together with those from other stakeholders, provide an opportunity for clinical care to be more transparent, and yet a challenge to professionals in communicating to their patients about the cost, benefits and harms of interventions. It also adds pressure to apply research to practice. This requires the easy and fast availability of reliable information for innovation and creative problem solving and a flexible and adaptive information system.

In large organisations, there are many stakeholders with various levels and degrees of accountability, responsibility and perspectives. Health care decisions are increasingly complex, especially in an environment of shrinking resources, increasing politicization and social pressure to perform. A study of the organizational barriers in the Hospital Authority (Cheng 2002) indicated that there was a perceived lack of management support and the traditional rank consciousness, and work role delineation by profession (doctor, nurse, allied health, etc). Under these circumstances, organisational memory is important for learning and risk management.

Information barriers

My study on Hospital Authority clinicians (Cheng 2002) attested to the presence of personal and psychological barriers in accessing quality information. The lack of time (only 1 hour per week was available), the urgency of the problem in hand, the clinicians' awareness (or not) of the existence of evidence have influenced them in activating a search or not. Bandura's self-efficacy construct (1977), i.e. the strength of people's convictions in their own effectiveness is likely to affect whether they will even try to cope with given situations, was found to be applicable as a general concept determining information behaviour (Cheng 2002). The clinicians' low self-efficacy and their actual skills and knowledge of searching have correlated with the use (or non-use) of electronic information services for problem-solving.

New evidence from clinical research emerges on a daily basis and often invalidates previously accepted standards and protocols - there is regular need of valid information about treatment and diagnosis for patient care. Hence, relying on each individual to repeatedly filter and appraise the same dearth of data in the organizational context is wasteful and may lead to inconsistent results and conclusions. The need to share existing knowledge and to disseminate the needed information to the right people at the right time to generate new knowledge is beyond doubt.

Knowledge Management and Evidence-based Practice - Implications for Health Services Management

Many of us suffer from 'information overload' because there simply is too much information, old or new, medical or otherwise, print, electronic or multi-media, available for processing from day to day (Arndt 1992). Too much information will be confusing, especially when messages are mixed or contradictory. Some people have "Information Anxiety", a frustration that even though you have so much information, but it does not tell you what you need to know for the problem case in front of you. When you try to do some searching, you are faced with another barrier - the "jungle" in the information world.

Hence value is added when someone manages, through their own skills and knowledge, to weed and filter the information, to manipulate and turn it into the best available and ready-to-use information for application to practice.

> *"People need filters to separate the quality information from the junk, and to apply judgement to what remains... The added value is the judgement that accompanies it." ... (McRAE H 1994, 175)*

At the end of the information chain is knowledge creation and application. The creation of local knowledge befitting the environment requires experience and judgement of the practitioner.

> *"Judgment is a great asset; it makes the diagnostician and the surgeon both supermen" (Mayo, Sir Charles Horace 1929)*

Principles of Knowledge Management

Davenport and Prusak (1998) provide a systematic overview of these basic concepts and the working definition of KM in organizations. They define KM in a framework that I shall refer to as the "data-information-knowledge (D-I-K) continuum".

Data is a set of "discrete, objective facts about events" (Davenport and Prusak 1998, 2) while information is "data transformed by the value-adding processes of contextualisation, categorisation, calculation, correction and condensation (Davenport and Prusak 1998, 4). Knowledge is derived from information through human interactions -- comparisons, assessment of consequences, making connections and conversations.

Knowledge has more value because it is closer to action than data and information. Value is added to data, turning them to information. Information is appraised, assessed, compared; and these actions turn information into knowledge. According to them, knowledge can also move down the value chain, a process which they called "de-knowledging", the return from knowledge to information and data. The most common reason is too much volume.

In KM, information is regarded not only as a process, but also an asset that can be exploited to increase the value of the organisation. Information itself is not the ultimate product: how to exploit information to generate new local knowledge for improvement of organisational performance is the desirable outcome. Knowledge assets are in some cases hard to pin down. Like atomic particle that can appear to be either a wave or a particle, depending on how scientists track it, knowledge can be seen as both process and stock.

The difference among data, information and knowledge is only a matter of degree, but they are not interchangeable concepts. The D-I-K framework is useful in that it provides a perspective to identify and understand those processes and actions leading to the next stage of the information chain, the generation of knowledge.

The Knowledge Cycle and KM

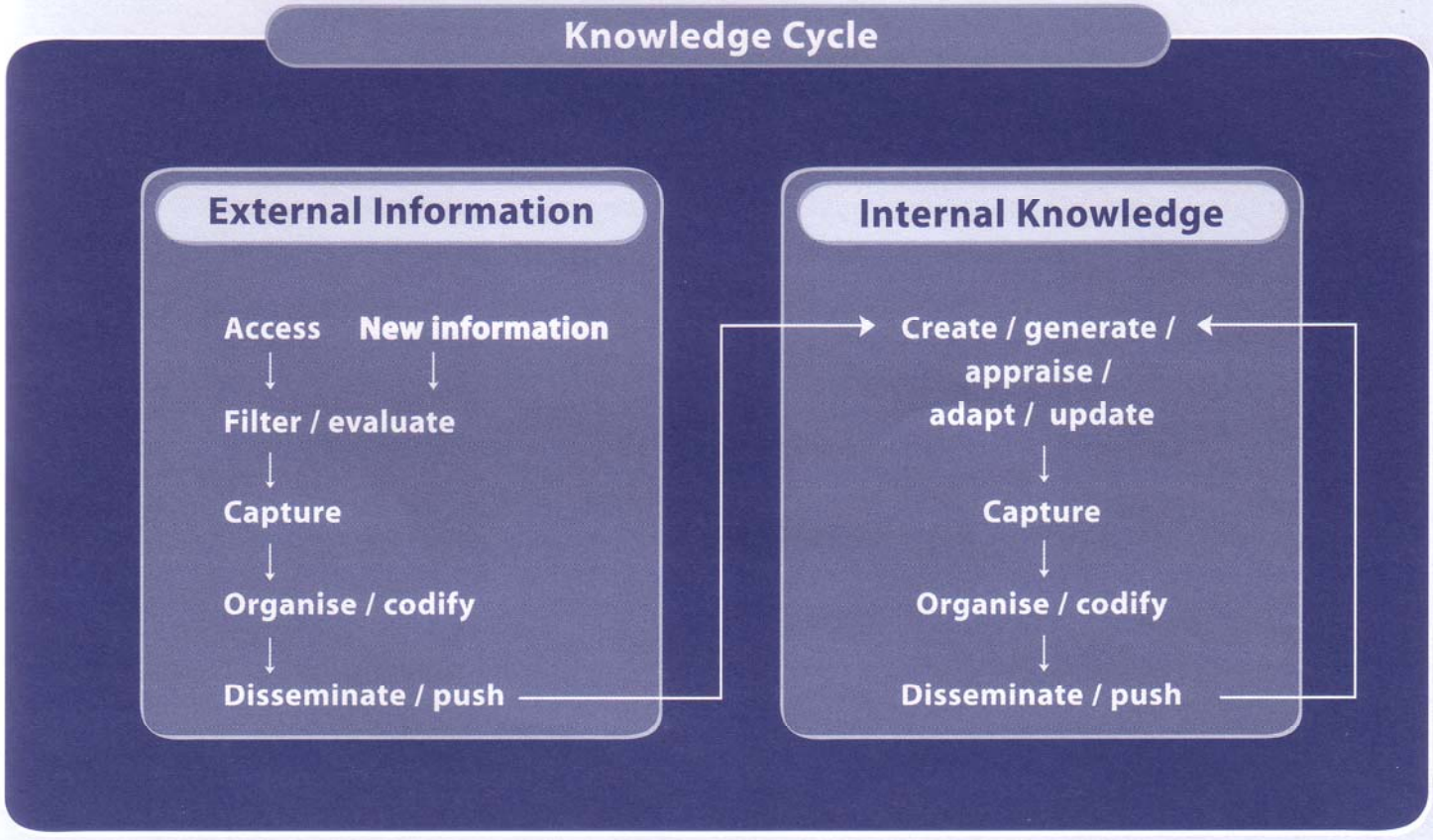
Organizations, like individuals, learn through a cycle. The cycle starts through a sequence of discrepancy, challenge and conflict. This is followed by the identification of the problem, the exploration of the causes, research and analyses of solutions, development and implementation, reorientation and reform and new equilibrium (Candy 1991).

The diagram represents a hypothetical model of how knowledge is generated from accessing external information. Through the processes of filtering, critically appraising the information, organising and disseminating it, new knowledge is formed through transforming the best external evidence through contextualisation, making comparisons and connections. We use this new knowledge to guide our action according to value system. This resulting new knowledge will in turn be captured, organised, disseminated, used and assessed. The outcome of the assessment will be fed as new information to others. When new information is found, it is being fed into the process of evaluation, contextualisation, and comparison again. The knowledge process is cyclical.

How fast the cycle travels, from problem identification to solution or reform, may be crucial for organizational survival. It involves not only the presence of knowledge based on accessible information but also a competent, motivated workforce with the skills to apply and manipulate knowledge. That is the reason why KM comes into the picture.

There are many definitions of KM in literature and until now there is no consensus. The definition from the Harvard Business Review emphasizes the two distinct levels of KM - one for the individual knowledge worker that cumulates to become organisational knowledge. KM is:

"the process of making creative, effective and efficient use of all the knowledge and information available to an organisation for the benefit of its customers, and through the creation of new knowledge to improve or produce new products or services for sustainable competitive advantage especially for knowledge workers."



Knowledge Management and Evidence-based Practice - Implications for Health Services Management

The D-I-K Continuum in Evidence-based Health Care

The D-I-K framework is analogous to the main stages of EBP propounded by Gray (1997) -- producing evidence, making evidence available and using evidence/getting research into practice. The actions which Davenport and Prusak described in transforming information into knowledge, comparison, conversation, connections, can be employed in developing local clinical practice guidelines, or appraising an intervention or a treatment.

Produce evidence and make evidence available by turning data into useable information

Organizations should actively identify and strategically disseminate evidence that is meaningful to those who need them, in a form and in a situation desired by clinicians and managers alike. Managerial support, filtering and critical appraisal of the information obtained will be a crucial part of that role.

KM and Evidence-based Health Care, A Comparison*.

Evidence based health care

Process	**Produce evidence and make evidence available**	**Using evidence in practice: for individual patients, for populations**
Actions	**Ask answerable questions** **Accessing/searching for answers** **Compile systematic review** **Conduct meta-analysis**	**Critical appraisal** **Application - developing local guidelines** **Assessment**

KM

Process	**Transform data to information**	**Transform information to knowledge**
Actions	**Contextualise** **Calculate** **Categorise** **Correct**	**Compare (situation)** **Weigh consequences (decision)** **Conversation (opinion/exchange)** **Connections (other knowledge)**

**Adapted from Davenport and Prusak (1998) and Gray (1997)*

In HA, these KM concepts and tools become useful in the organizational or system level. The HA promoted evidence-based philosophy since 1998, and set up the Clinical Effectiveness Unit (CEU) and the Knowledge Management Unit in 2000 to institutionalize EBP initiatives. The efforts culminated in the launching of a KM platform, with comprehensive web-based resources - the e-Knowledge Gateway (eKG).

To reduce clinicians' work to synthesize the evidence individually, HA makes available secondary journals, databases and web sites on critically appraised topics and integrated evidence e.g. Cochrane Library, Clinical Evidence, Evidence-based Medicine, Evidence-based Nursing, the Oxford CATBank.

To keep practitioners up-to-date and stimulate health services innovation, electronic alert service according to users' need can provide easy, fast and reliable information. In a survey (2003) on the usefulness of this highly selective service in the Hospital Authority, over 90% of respondents found the alert to be very useful or useful. Half of them found the service providing "essential evidence ... vital for clinical management", and the other 40% found the alert useful for professional development.

Use and get evidence into practice by turning information into knowledge

KM is about developing effective and efficient ways, not just disseminating incoming information; but also ensuring the knowledge generated will be captured, shared, re-used, assessed and fed into the adaptive knowledge cycle. Organizational memory is important for learning and risk management.

In HA, the eKG portal, where external evidence is filtered and disseminated and internal knowledge captured and shared, has been implemented as a KM tool to support EBP. eKG development strategies include personalized service with customization of specialty and disease focus. Information residing in eKG is filtered by information professionals and selected and value added by experts in the field. Information is evidence-based and regarded as "less is more". Clinical content is organized or disseminated using multi-disciplinary approach.

An electronic forum created by librarians for clinicians and managers can be useful to discuss and exchange opinions on the application of the evidence in local clinical practice. It is believed that in providing an easy, filtered access to evidence, and a convenient and open forum for discussions of its local context and applications, the creation and capture of new knowledge (action or no action is needed) will be expedited.

Important, clinically relevant interventions are selected, reviewed, published as EVIDENCE, EVIDENCE-in-Context bulletins that are integrated with full-texts through hot-links to the Internet, Intranet, locally mounted or licensed databases. These clinical bottomlines are disseminated widely for discussions, and if necessary, for policy setting or implementation in practice.

Instead of spending a lot of time in obtaining the evidence, HA healthcare professionals can then concentrate on the more important task of applying the evidence in their daily practice and decision-making. Internal recommendation on treatment and management is the result of lengthy discussion and consultation amongst stakeholders. These clinical practice guidelines developed by experts and groups are in turn captured in the knowledge gateway for their use and continuous development. They are complemented by comprehensive databases of international CPGs accessible at wards and at home.

KM is not just about building larger databases, but about developing skills to apply and manipulate knowledge. The increasing technical complexity of many health interventions and the growth of EBP highlight even more the need to develop knowledge workers in critical appraisal, analysis, and the application of evidence to their daily practice. There are reports from the literature (Scherrer CS, Dorsch JL 1999, Smith JT 1996) and from Web sites that they are increasingly practiced in Canada, United States and other parts of the world. In HA, many workshops on quality filtering in systematic literature searching and critical appraisal skills have been held.

Recent research found that reminders at time of consultation and patient-mediated intervention (Grimshaw 2004) work better to change practice (moderate to large effect) than educational outreach programmes, audit feedback, multi-faceted interventions. Hence, "baking knowledge into practice", so that it becomes an intrinsic part of clinical process may become the strategic direction of health services management. Thus, the representation and codification of knowledge for real-time clinical decision-support may become important development in the near future.

Knowledge Management and Evidence-based Practice - Implications for Health Services Management

Conclusion

Given a constantly changing environment, I certainly agree with Alvin Toffler that: "The illiterate of the 21st century will not be those who cannot read and write, but those who cannot learn, unlearn, and relearn". The term "information literacy" does not only refer to the competency of an individual to be able to search for information, critically appraises it for relevance, innovates and applies it to his work, but will be equally valid for organizations that recognize the importance of information and knowledge.

Tomorrow, change is certain and change is fast. Traditional paradigms for management - Newtonian world view of stability and orderly change - are no longer suitable for rapidly changing and highly complex environments. This is particularly apparent in 21st century world view - that calls for organizations to anticipate change and adapt quickly or better still, lead the change in their favour. I believe the application of KM principles and tools to EBP will provide health service management (individuals or organization) to proact and adapt in the face of continuing changes.

Grace Cheng, PhD ■
Hospital Authority

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Partnership for Health

When we look back over the past few years, many people in the healthcare sector are quick to point a finger and assign blame for our deteriorating healthcare system. In fact, we have come a long way since the establishment of the Hospital Authority in 1991. According to the Health, Welfare and Food Bureau, "over the years, we have developed an enviable healthcare system, which provides an accessible quality, equitable and affordable service." The only concern is the sustainability. Owing to the aging population; increasing expectations and demands from consumers/patients; the advance in medical technology and innovative medicines; more co-morbid illnesses associated with chronic diseases. It is a real challenging task for the healthcare administrators and clinicians to maintain such high standard of services, with a reducing healthcare budget.

Heavy workloads, limited career opportunities, long waiting time for patients and restricted access to best drugs and technologies are some of the criticisms frequently appeared in the media. These are undoubtedly debatable but still can be viewed as a useful reference to navigate our way forward. As healthcare executives, we owe it to ourselves to appreciate the good we have accomplished in the past. Our goal is clear. We are here to serve the local community - to move steadily towards a strong and sustainable healthcare system.

Partnership to deliver high quality service

Health is Wealth. When we were young, we gave up our health to gain wealth. When we became older, we gave up part of our wealth to regain health. Health is the key to our life. It affects every part of our daily living. We don't realize how lucky we are until we fall a victim to a terrible illness.

The most important investment all of us make and in the same way we need our government is to increase healthcare spending. An investment in health is an investment in human capital. But better funding is more than just numbers alone. It involves minimizing wastage, and reallocating resources for more effective patient care. A good healthcare system is also sustainable in a long term. It should facilitate patients to make their own informed decisions and save them money as well as reducing systemic cost efficiencies.

This approach and its initiatives point in one direction - Partnership. Healthcare executives as much as government, clinicians, allied healthcare professionals, researchers, academics and pharmaceutical companies are vital elements of the solution.

Partnership is more than just Private Public Interface. It means a healthy collaboration between two or more parties. In our battle against compartmentalization, we need to develop open communication, share common objectives, align our goals and establish a mutually trusted and respected working environment.

United for Success

As the proverb says, "None of us is better than all of us". Team means "Together Everyone Achieves More". It is always easier said than done. We have to recognize that no one element - be it administrators, medical professionals, government or the pharmaceutical industry can tackle the challenges alone. But through collaborations, we can strengthen Hong Kong's medical capabilities and realize our vision of an international medical hub.

What this means for all of us involved is that we should focus on the priority we all already share - the well being of the patient. It is a win-win-win situation when we have a common goal and the collective wisdom to accomplish it.

The more we know, the more we recognize we don't know. The more we have accomplished, the more we recognize we need partnership. Our patients' health is in our hands. They are waiting - waiting patiently but desperately.

In order to move forward, the healthcare executives are in the driver's seat.
They are not part of the problem, but are the key to the solution.

Stephen Leung ■

Food for Thought -

What is Waste?

Waste is when we debate forever,
And fail to take action
Waste is when doctors order unnecessary tests,
And there is no sanction.

Waste is when we fight and destroy;
Instead of teaming to work together
Waste is when nurses see themselves as nurses
And managers fight with each other.

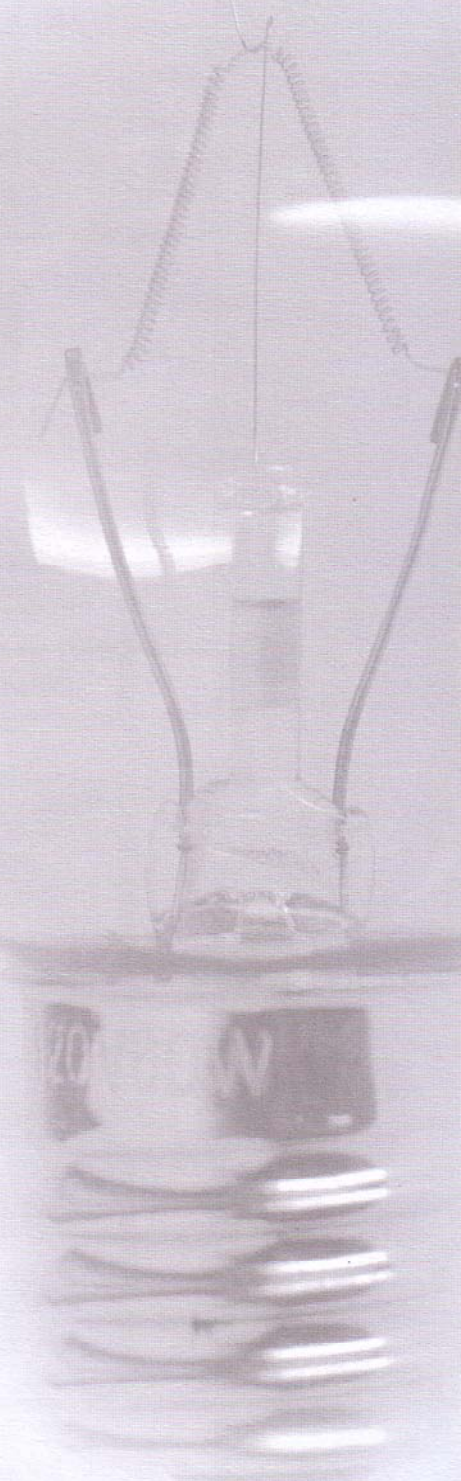
Waste is when we engage in endless meetings
Without the resolve to make a difference
Waste is when there are too many hand-offs
And computers are considered cumbersome

Waste is when the good staff leave
And we have to cope with high turnover
Waste is when we stick with the bad apples
And wonder when they will ever turn sour?

Waste is when we have a very busy organization chart
And we try to measure everything
Waste is when we fail to empower our patients
And love to see them silent.

Waste is our number one enemy
We must fight waste today and NOW!

Margaret Tay ■



Report

Joint Executive Program on Health & Medical Service Development in Mainland China

Project Name

6 day Health Executive Program on Health & Medical Service Development in Mainland China (26/3/05-31/3/05)

Organizers

- The Hong Kong Society for Health Service Executives
- The Hong Kong Association of Health Care Professionals (香港衛生護理專業人員協會)
- Zhejiang University (浙江大學)

Aim

To provide a platform for the Society's members who are local health executives for exchanging views on contemporary health policy and management with health academics and health executives of Hangzhou, China. (Refer to 團長的話)

Concluding Remarks

It took almost a year for the course planners Alice and Fowie to plan the program which is a new attempt for the Society to have collaboration with another local professional organization and academics from Mainland China on a joint project. Thirty members from both associations with different professional backgrounds such as medical doctors, nurses, para-medics, health managers joined the trip which was headed by our Society's chairman Dr Ma. The learning activities of the program which have drawn members' full attention, ranged from class room teaching by renowned university professors and group discussions on assigned topics to hospital visits to both private and public health enterprises. The program content followed our intended aim covering the following areas:

1. 國內醫療衛生發展及前景
   蔡仁華 — 國家衛生部原政策法規司司長，現中國衛生經濟研究所所長
2. 國內醫療市場、醫療融資，包括企業參與安排及投資等
   裘華生 — 民營浙江廣福醫院院長
3. 國內公共衛生政策、社區醫療
   李魯 — 浙江大學社會醫學研究所所長
4. 國內醫療管理改革，包括醫療架構、專業註冊認可、專業保險等
   王楨 — 浙江省衛生廳醫政處
5. 中、西醫結合應用
   鄔成霖 — 杭州市中醫院副院長，浙江中醫院教授

Of course, there were many other extra-curricular activities members similarly enjoyed so much - the experience of doing massage in a local bath house inside university campus, a side tour to "West Lake", a late night supper at a local muslin restaurant, etc etc.

We received a lot of positive feedbacks on the program at the post-tour gathering where we have also exchanged the photos, souvenirs and lecture notes. Members present indicated their keen interest in joining our Society's future activities.

團長的話

隨著香港回歸祖國，兩地的連系日趨緊密，各方面的溝通、交流愈見頻繁，其中醫療衛生界更是往來不輟，絡繹於途。

今次香港醫務行政學會與香港衛生護理專業人員協會聯同浙江大學合辦的「醫務行政研修班」，是在各種交流活動之外，另闢蹊徑，以正統上課形式加上實地考察，讓香港的專業人員能夠具體而細微地認識祖國的醫療保健制度及面對之難題，未來改革方向和資源投放策略等，從而作為解決香港醫療保健體制及融資等一連串問題之參考，所謂「他山之石，可以為鑑」也。當然，通過互動交流，團員們亦可以向內地專家們反映香港過去多年醫療體制改革之經驗，以收「教學相長」之效。

我們和所有團員都對今次之研修班抱有很大的期望，對內地學者專家今次的熱情參與，浙江大學在多方面之妥善安排和配合，深為感動。我們相信這祇是兩地更緊密交流的開始，在未來的日子，將會有更廣泛的接觸，並為兩地長遠、完善醫療保健體制的宏圖，不斷注入新的動力。

團長：馬學章醫生 林崇綏博士
二零零五年三月

Alice Tso ■

Application Form

Hong Kong Society of Health Service Executives

Membership Application / Renewal Form 2005/06

(For renewal, please fill in any changes of personal particulars if necessary or just write down your name, ID number and send in your payment)

Name (Family Name / other name)

Title : Prof / Dr / Mr / Ms / Mrs HKID No.: - Sex : M / F

Position Held : _____

Place of Work : _____ _____
(Department / Division) (Organization / Institution)

Nature of Organization : ☐ HA ☐ Government Department ☐ Private Hospital ☐ Academic Institute
☐ Other Public Organization ☐ Other Commercial Organization

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Contact Phone No. : _____ Fax No.: _____

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Professional Qualification : _____

Qualification in Health Care Management : _____

I wish to ☐ apply / ☐ renew ---------- ☐ life / ☐ full / ☐ associate membership
I wish to ☐ apply for membership of the Australian College of Health Services Executives as well
Membership fee : $3,000 - life member $300 - full member $200 - associate member
$1,800 - full member (for dual membership of HKSHSE and ACHSE)
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Qualification for full / life membership: holding a degree in management or a full time managerial position

Please send this application with cheque payable to **" The Hong Kong Society of Health Service Executives "** to :

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