Hong Kong College of
Health Service Executives

Newsletter Issue 3 2006/07

Message from the President

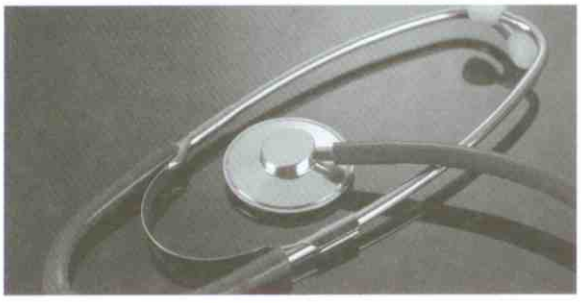
There are some statements or beliefs concerning health care that have been quoted repeatedly without going through careful critique. In view of their far-reaching implications, I think they deserve further elucidation and clarification:

Medical savings account and Healthcare vouchers are effective means of health care financing for Hong Kong

The idea is attractive since we already have the Mandatory Provident Fund and there is already a similar mechanism in Singapore. However, it is recognized that medical savings accounts have their pitfalls. They are payroll-dependent, and do not provide any risk pooling effect for the population against major and/or devastating illnesses. Thus those most at risk of catastrophic illnesses (meaning the elders) will not be provided with adequate protection with this method of health care financing. It has also been shown in Singapore that such savings accounts could not serve as a disincentive to reduce overall health care spending. Whether it can serve as a supplementary public health care financing tool is still debatable, as it is not promoting health care equity across the whole population (just like paying ones health care bills from out-of-pocket money), and would incur significant administrative costs.

The idea of health care vouchers probably follows that of education vouchers, with the potential merit of enhancing competition among health care providers by allowing government subsidies to follow patients' choices. However, we must remember that unlike primary education which is universally applicable to every child, the need for health care differs vastly among people. Many people need very little health care for most of their life span, while some people require a lot of medical care over a long period of time. To give every resident an equal share of public health care resource every year will grossly reduce the amount available to those having huge health care needs, while for the majority of people the voucher may even induce moral hazard and inefficient use of health care resources.

Hong Kong with its renowned expertise in medical care can become the regional hub for medical tourism



A recent visit to Thailand by a delegation of the College provided members some insight into the topic of "medical tourism". Indeed, it may be a misnomer to coin this term in describing the phenomenon of people seeking medical care from abroad, because it contributes relatively little to the tourism industry of the providing country. The Thai health care sector calls it "international medicine", and that sounds more appropriate. We were told by our Thai friends that there were some pre-requisite conditions for a thriving international medicine business.

First, there should be excess capacity of the health care system in relation to the health care demand of the local people. This is well illustrated by the recent saga of pregnant Mainland mothers flocking to Hong Kong for delivery. The already stretched capacity of the Obstetrics service for the whole territory is in no time overwhelmed by the high influx of expectant Mainland mothers. The situation for Thailand was rather unique in that there was encouragement of the private hospitals by the Government to expand their inpatient capacity for the period immediately before the Asian Financial crises of 1997. Following the sharp financial downturn in 1997, most of these hospitals were left with very low occupancy rates. In order to survive, these hospitals started to promote their health care services to local expatriates and then residents of foreign countries with very competitive fee schedules. This was the starting point of the whole matter.

The second prerequisite is to have a reputable health care professional workforce. Many Thai doctors were trained in USA with specialty board certification. That gives strong confidence to the potential foreign clients; many of them are from the developed countries. The third factor is the level of living. The level of living in Thailand is relatively inexpensive, and that makes both the medical fees as well as cost of staying in Thailand very affordable to the clients. Finally there are also cultural factors that must be taken into account. The Thai people are well known to be friendly and receptive of foreigners. They also possess fairly good command of English.

It is the combination of all these factors that make Thailand so successful in attracting international patients. However, even with all its tourist attractions, ubiquitous shopping facilities and refreshing resorts, the increase in tourists related to health care services is not significant at all. If Hong Kong really wants to offer its well acclaimed medical expertise to the international clients, then we need to review whether we have all the features mentioned above. Otherwise we need to explore other models for serving as a regional medical hub. Although some people argue that Hong Kong can attract wealthy patients from the Mainland, so far the number of such patients coming to Hong Kong is small save the pregnant women whose main target is either the right of abode for their babies or the avoidance of sanctions from the Mainland for violating the one child policy, or both.

Workload distribution between public and private sectors

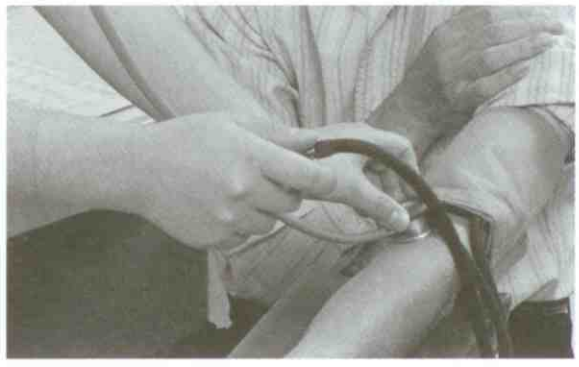
There is a frequently quoted statement that with less than 50% of the registered medical workforce in Hong Kong, the doctors of Hospital Authority

(HA) shoulders 90% of the health care burden. With this statement comes the verdict that there is gross imbalance between public and private health care sector, and the culprit is the expansionistic strategy adopted by HA over the past decade.

As I have pointed out previously, such a statement is far from being accurate. The percentage of so-called health care burden actually refers to the ratio of hospital bed numbers between HA and private hospitals. But we need to make a lot of adjustments because there are several types of inpatient services that could not be taken up by the private hospitals. These include the psychiatric beds (both voluntary and gazetted beds), the beds for long term care of severely mentally retarded children, the infirmary beds that cater for members on the Central Infirmary Waiting List (CIWL) kept by the Social Welfare Department, the isolation beds designated for epidemic outbreaks and the acute beds for serious trauma victims. Of course we should also make provision for the number of private beds in public hospitals for more accurate comparison. Even then we are only talking about inpatient services. If we also take into account the clinic consultations for primary and specialist care, then the workload distribution between the two sectors becomes a very complex matter, especially when we do not have reliable data regarding the throughput of private clinics. So it would be imprudent to draw any conclusion from such oversimplified statement, and the vow to stop the expansion of HA may become a slogan without a sound foundation. However, for the sake of political correctness, such statement has been re-iterated again and again by clinician leaders, politicians, academicians and private sector service providers alike. I hope policy makers can take note of the above caveats when referring to such statement for their decision making process.

Regular comprehensive body checkup is the way to practice preventive medicine

Nowadays the importance of preventive medicine is gaining momentum world-wide. In Hong Kong there is in the lay population a belief that preventive medicine is about having regular comprehensive body checkups involving a batch of different diagnostic tests and examinations. Indeed many private hospitals or medical centres provide such body checkup packages with a spectrum of components and prices to the general public without the requirement of medical referral. Obviously we cannot deny that such tests and examinations do very occasionally detect some abnormalities and allow early intervention for their treatment.



The issue is whether such comprehensive checkup is a cost-effective way to safeguard population health. Since in most cases there is no medical referral, many tests are either not indicated because of very low yield, or difficult to interpret because of existing co-morbidities or some other personal factors. In some cases, false-positive results may even cause unnecessary harm to the individual because more invasive investigations are required to repudiate such results. In many developed countries, there are guidelines developed by professional bodies to advise on the ordering of screening tests with reference to the local epidemiological data and disease pattern. Apparently such guidelines are lacking in Hong Kong. In the last few years, we have invested a lot of public resource in the prevention and management of infectious diseases. This is understandable in view of the immense political pressure following the SARS epidemic. But that should not prevent us from putting emphasis on the prevention of non-communicable diseases that are imposing heavy health care burden to society. With the collaboration of clinical epidemiologists and specialists in clinical diagnostics, we should be able to come up with scientifically sound guidelines for people to take screening tests appropriate to their demographic and health status. Diagnostics service providers should not aim at maximizing their profits by promoting unselective use of such tests to the public, and one way is to encourage people to consult their family physicians before taking such tests.

Dr H C MA

Private Health Insurance: The Swiss and Australian Experience

In anticipation of Government's proposal on health care financing reform, many have advocated expanding private health insurance in Hong Kong as a possible way forward. Some suggested that Government should grant tax incentives for persons with private health insurance. Private insurance is seen as a way to inject more money into the health care sector, especially the private sector, without having to add burden to Government. This article examines the current private insurance market in Hong Kong, and contrasts it with that in Australia and Switzerland.

Health Insurance

Unlike social health insurance, private health insurance is generally purchased on a voluntary basis, either by individuals or by groups (most employers). The premium varies depending on the benefits and the health condition of the insured (known as experience rating). Consequently, the elderly and persons with existing medical conditions are required to pay prohibitively high premium.

Private Health Insurance in Hong Kong

The private health insurance market in Hong Kong is highly unregulated. There are no requirements that employers must provide health insurance for their employees. Insurance companies are free to sell any product they wish. There are no requirements on benefits or premium rate. The result is that most of the plans purchased provide very inadequate protection. The elderly and persons with pre-existing medical conditions are generally excluded because of the extremely high premiums. Many persons with private health insurance also go to public hospitals during major illness, because the benefits provided by their insurance plan would cover only a small fraction of the expenses if care is rendered in private hospitals. While more than 2 million persons (almost one-third of the population) in Hong Kong are covered by some form of private health insurance, 95% of the patient days came from public hospitals. Many plans just provide general outpatient coverage and others a small indemnity payment (often only a few hundred dollars a day) in the event of illness requiring hospital stay.

Private Health Insurance in Switzerland

The private health insurance market in Switzerland was not regulated until 1996. Since 1996, health insurance has been made compulsory (the scheme is similar in many ways to Hong Kong's Mandatory Provident Fund), and insurance companies wanting to sell statutory health insurance must register with the Government and are prohibited from refusing anyone. Registered plans are eligible for government subsidies, and must cover

a basic package of benefits defined by the Government. The basic package includes coverage for outpatient, inpatient and medical rehabilitation services. In addition to the mandatory insurance, policy holders can take out additional insurance to cover semiprivate or private room accommodation. Premiums are community rated – subscribers, regardless of age and health status, pay a fixed percentage of their income. An equalization fund was established for risk adjustment and transfers between companies depending on the risk profile of their customers. Policy holders who agree to limit their choice of doctors and hospitals or to increase their amount of co-payment pay a reduced premium. Low income persons are eligible for reduced premiums.

Private Insurance in Australia

Australia has a compulsory national insurance scheme known as Medicare. A levy of 1.5% to 2.5% of income is applied on taxable income of individuals. Under Medicare, residents are eligible to receive free treatment in public hospitals and subsidized outpatient care and pharmaceuticals.

Private health insurance is voluntary but regulated. Registered plans must practice community rating. The Government provides financial incentives for people to purchase registered private health insurance plans. Private insurance policy holders receive 30% rebate on their Medicare levy. Private insurance provides benefits such as choice of doctors in the private sector, choice of private hospitals and the more flexible scheduling of care for non-urgent conditions. Lifetime Health Cover was introduced in 2000 to encourage more residents to take out private health insurance. Under this scheme, persons joining a registered private health plan before the age of 31 and staying with the plan will pay a lower premium throughout their lives relative to persons who join at an older age. Over 45% of the population have private health insurance.

Lessons from the two countries

It is clear that from the experience of these two countries that the private health insurance market needs to be regulated. Simply granting tax credits to persons with private health insurance without first having a health insurance regulatory system in place is not likely to produce desirable impact. The industry and government should get together and work out a registration system. Registered plans must provide adequate hospitalization coverage, and their premiums must be community rated.

The existing situation in Hong Kong is clearly unsatisfactory. Private health insurance in Hong Kong has not, in any significant manner, diverted demand away from public hospitals. Its impact on creating demand for private hospitals is modest. Policy holders do not always have greater choice of doctors and/or hospitals in the event of major illness. Insurance companies also complain about the low profit margin, as the many of the plans cover general outpatient care, in which the probability of claim to the maximum limit is very high. In short, no one is benefiting from the current state of affairs.

Acknowledgement: An abridged version was published in the South China Morning Post of 3 July 2006.

Prof Peter P. Yuen

Medical Tourism - Are We Ready?

Medical tourism (also known as Health Tourism), the act of traveling abroad to obtain health care, has emerged in recent years as a major new trend in the global healthcare industry It is perceived as one of the fastest growing segments in healthcare industry with tremendous potential for future growth.

Medical Tourism is a simple concept: people can combine medical treatments with vacations, and use the savings on the medical care to pay for the vacation. The reasons patients travel for treatment vary. Many medical tourists from the United States are seeking low-cost medical treatment. In Canada, it is often people who are frustrated by long waiting times. In Great Britain, the patient can't wait for treatment by the National Health Service but also can't afford to see a physician in private practice. For others, becoming a medical tourist offers a chance to combine a tropical vacation with elective or plastic surgery.

The driving force behind the medical tourism industry is the so-called "First World treatment at Third World prices". The demand for cost effective specialized care is emerging from the developed countries where there has been a decline in public health care spending and a rise in life expectancy and non-communicable diseases that requires specialist services. Medical care, packaged with traditional therapies and other traditional systems of medicines, attract high-end tourists especially from European countries and the Middle East. There are also other benefits that are beyond the cost equation including excellent care from highly qualified doctors, more personalized care with higher physician-to-patient ratio, and even receiving services that are not yet approved by the U.S. Food and Drug Administration.

Medical Tourism has emerged as a viable health care alternative through the combination of a variety of national and global factors: the exorbitant costs of healthcare in industrialized nations, the ease and affordability of international travel, the explosion of online commerce and communication, currency exchange rates that continue to favor citizens in the industrialized world, and the emergence of high quality, cutting-edge health care services in a range of non-Western countries across the globe. As more and more patients from Europe, US and other affluent nations with high medical care costs look for effective options, Asian countries such as India, Thailand and Singapore, which have advanced medical facilities, a pleasant climate and tourist destinations are gaining popularity.

Medical practices in these "Third World" countries can charge less because their overhead, including salaries, is much less, and they often have much lower litigation expenses. While taking care of health needs at deep discounts, shopping excursions,

river tours, sight-seeing, nature excursions, intellectual pursuits, religious pilgrimages, cruises, ancient site tours, and trips to nearby beaches can all be arranged around a medical appointment schedule. Medical Tourism can certainly be a win-win proposition.

Some important trends show that the market for medical tourism will continue to expand in the years ahead. Medical tourism will be particularly attractive in the United States, where an estimated 43 million people are without health insurance and 120 million without dental coverage -numbers that are both likely to grow. Patients in Britain, Canada and other countries with long waiting lists for major surgery will be just as eager to take advantage of foreign health-care options. In contrast to the long waiting lists and increasing health care prices in developed nations' markets, medical services will be delivered to tourists at a cheaper price.

An Educational Tour to Thailand

Medical tourism in Asia is relatively new, brought on in the aftermath of the Asian Financial Crisis that led private hospitals to seek alternative revenue sources. In order to have better understanding towards medical tourism in South-east region of Asia, an educational tour to Thailand was organized by the College for its fellows and members. A total of twenty-two participants including Hong Kong healthcare professionals and executives joined a 4-day tour from 28 September to 1 October 2006 which included visits to private hospitals or health care groups in Bangkok and meeting with representatives of the Ministry of Health.

During the tour, we visited 3 hospitals namely:

- *Piyavate Hospital,* a modern 27-storey hospital in west-central Bangkok with centres of excellence including radio-oncology, gene therapy etc.
- *Samitivej Sukumvit Hospital,* a private fee-for-service hospital with 250 beds serving international patients especially the Japanese community nearby. It is also a Mother and Baby Friendly Hospital awarded by UNICEF.
- *Bumrungrad International,* a premier hospital serving as a regional referral centre for specialty care as well as medical tourism.

We also met with representatives from the Ministry of Health who provided us with an overview of how Medical Tourism was positioned in Thailand.

Medical Tourism in Thailand

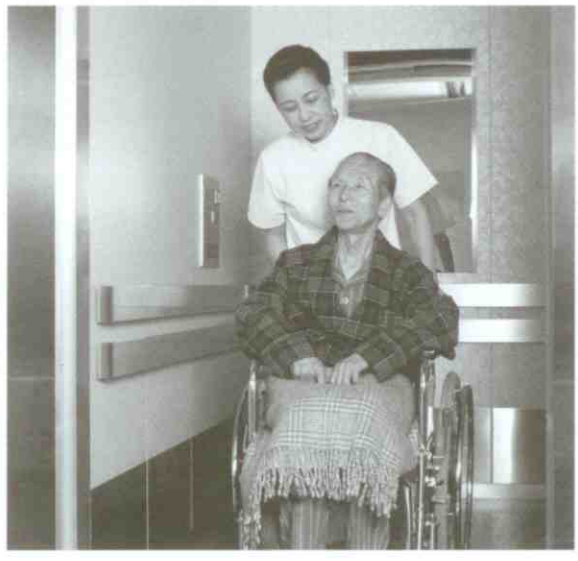
Being an internationally well known tourist destination over the past few decades, Thailand is able to attract a large volume of patients as it is itself well-reputed as a tourist haven, with a variety of existing tourist attractions for recuperating patients, a relatively low cost of living, expat-friendly locals, and a respectable quality of healthcare.

After the economic crisis, health care was chosen as one product to accelerate the country's economy. The medical tour companies that serve Thailand often put emphasis on the vacation aspects, offering post-recovery resort stays. With the growth of medical-related travel and shifting of healthcare business towards medical tourism, Bangkok became a centre for medical tourism. The number of foreigners receiving care in Thailand rose to approximately 1 million in 2005. Although Ministry of Health does not explicitly support medical tourism, the government provides tax incentives by reducing tax on imported modern medical equipments.

Healthcare groups and hospitals also highlighted a number of attractions within the system as reasons for foreigners to choose visiting Thailand for health care:

- Peaceful, politically stable country
- Welcoming, caring, and service-minded
- No discrimination
- Low cost of living
- Best practice in:
  - medical service and healthcare delivery
  - hospital management and hotel services
  - information and electronic technologies
  - quality systems to deliver satisfactory services
- combining traditional spa, massage and also alternative medicines.

In order to ensure quality of care, major private hospital groups started attaining international accreditation from trusted accreditation organizations as the Accredited International Standards Organization or the Joint Commission on Accreditation of Healthcare Organizations. They also started cooperating with reputable medical research centres e.g. John Hopkins University or Harvard Medical School to attract premium tourists. Other measures such as partnering with domestic and international travel agents as well as partnering with international providers to market their products were also put in place.



The Downsides of Medical Tourism

- Medical insurance, or sometimes extended medical insurance, often does not pay for the medical procedure, meaning that the patient has to pay cash.
- With little follow-up arrangement, expensive care may be required if complications occur. As the patient is usually in hospital for only a few days, and then goes on vacation, complications, side-effects and post-operative care are then the ultimate responsibility of the medical care system in the patients' home country.

- Most of the countries that offer medical tourism have weak or different malpractice laws, so the patient has little recourse to local courts or medical boards if something goes wrong.
- There are growing accusations that profitable, private-sector medical tourism is drawing medical resources and personnel away from the local population, which results in the emergence of a two tier medical system: one, a government subsidized public health system, often quite sub-standard, and secondly, a highly developed and professional private sector. Although some medical organizations that market to outside tourists are taking steps to improve local service, it is hoped their governments will translate some portion of medical tourism revenues towards improving their state-financed health care systems for local.

Hong Kong as a Medical Hub

Medical tourism presents an opportunity for hospitals to fuel growth by tapping the potential of the international patient market. The idea of developing Hong Kong into a medical hub to serve people in the Mainland and elsewhere in Asia was recently raised.

In recent years, a list of facilitating factors including the increasing economic integration with China through the Hong Kong – Mainland Closer Economic Partnership Arrangement, the improving transportation network as well as the rising affluence of people in China further put Hong Kong into a favorable position to play a more prominent role in healthcare services provision for the whole Asia region. With increased prosperity in China, people are more health conscious and demand for higher quality healthcare services and products. Hong Kong's proximity, language, and historical ties with China give us a competitive edge over healthcare providers in other parts of the world.

Hong Kong has also established international reputation in the provision of quality medical services. Both public and private hospitals in Hong Kong are well equipped with modern facilities and equipments. Other intrinsic factors such as the sound infrastructure, focused approach in delivery of clinical care, and a rich pool of expertise from various specialized fields become the fundamental ingredients for Hong Kong to work along such direction.

In order to move forward to realize this potential, healthcare providers in Hong Kong may now consider to collaborate with the supporting industries, including pharmaceutical industry, travel service providers, IT and health insurance as well as partnership with universities. A sincere commitment to these alliances allows each stakeholder to focus on his own competencies for better integrating of services.

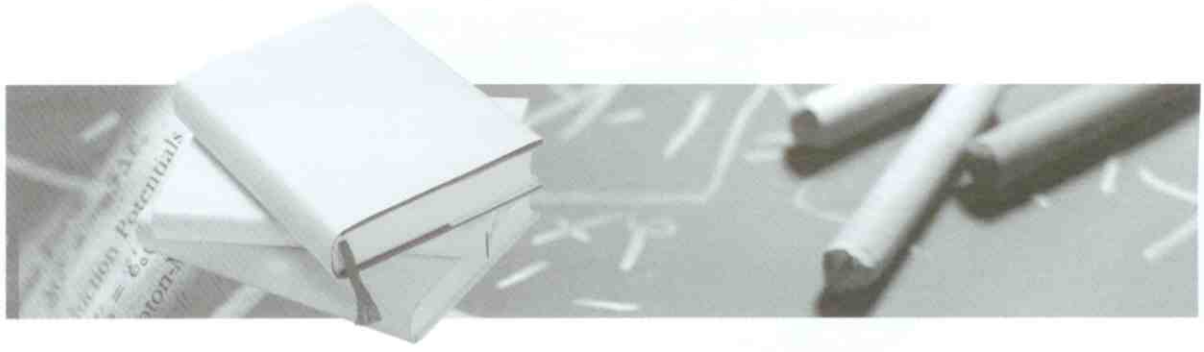
Other important considerations such as the high operating cost and the limited capacity of our health care system would need to be taken into account.

In conclusion, medical tourism is definitely a promising new industry in Asia offering prospects for hospitals or healthcare system. However, is Hong Kong ready to make this move yet?

Ms Tammy SO

Journals Update

No time to read health services management journals? In this issue and future issues, we hope to help by printing abstracts of some selected journals for you to browse through and keep yourself up to date with the most recent happenings in this field.



Health Systems

Claudia Sanmartin, Jean-Marie Berthelot, Edward Ng, Kellie Murphy et al

Comparing Health and Health Care Use in Canada and the United States

Health Affairs, Jul/Aug 2006, Vol.25; pg 1133, 10 pages

Results from the Joint Canada/United States Survey of Health (2002-2003) reveal that health status is relatively similar in the two countries, but income-related health disparities exist. Americans in the poorest income quintile are more likely to have poor health than their Canadian counterparts; there were no differences between the rich. In general, Canadians were more like insured Americans regarding access to services, and Canadians experience fewer unmet needs overall. Despite higher U. S levels of spending on health care, residents in the two countries have similar health status and access to care, although there are higher levels of inequality in the United States.

Management Competencies

Anthony R Kovnner, Thomas G Rundall

Evidence Based Management Reconsidered

Frontiers of Health Services Management, Spring 2006, Vol 22, Issue 3, pg3, 20 pages

Reports of medical mistakes have splashed across newspapers and magazines in the United States. At the same time, instances of overuse, underuse and misuse of management tactics and strategies receive far less attention. The sense of urgency associated with improving the quality of medical care does not exist with respect to improving the quality of management decision making. A more evidence- based approach would improve the competence of the decision makers and their motivation to use more scientific methods when making a decision. The authors of this article consider a study of 68 U. S. health services managers that found a low level of evidence-based management behaviours. From the findings, four strategies are suggested to increase health systems managers' use of research evidence to improve decision making: focusing evidence-management research throughout the organization, building a management culture that values research, and training managers in the competencies required to apply research evidence to health services management decisions. To aid the manager in understanding and applying an evidence-based approach to decision making, the article provides practical tools, techniques, and resources for immediate use.

Human Resources

Naresh Khatri

Building HR Capability in Health Care Organizations

Health Care Management Review, Jan-March 2006, Vol 31, Issue 1, pg 45

The current human resource (HR) management practices in health care are consistent with the industrial management model of management. However, health care organizations are not factories. They are highly knowledge-intensive and service-oriented entities and thus require a different set of HR practices and systems to support them. Drawing from the resource-based theory, the authors argue that HRs are a potent weapon of competitive advantage for health care organizations and propose a five-dimensional conception of HR capability for harnessing HRs in health care organizations. The significant complementarities that exist between HRs and information technologies for delivering safer and better quality of patient care are also discussed.

Health Care Costs

Heslop L, Athan D, Gardner B, Diers D, Poh BC

An analysis of high-cost users at an Australian public health service organization.

Health Services Management Research, Nov 2005, Vol 18, Iss 4, pg 232

High cost users generate extremely high costs when compared with average users in the same diagnostic group (DRG) They represent a major financial loss for a health service organization. The research was conducted using an area health service patient database for online analytical processing to produce descriptive statistics and graphs of "high-cost" and "non-high cost users". Trends and patterns were identified across key variables derived from clinical, financial and operational categories. The main results are: 20% of costs are spent by 3% of the population, elective admission is higher in the higher-cost group; tracheostomy has the most number of cases and is the most expensive DRG; LOS is mostly longer for complex cases. However, high costs can be attributed to other factors. In conclusion, these findings are potentially useful to patients, medical staff, management and health service decision-makers. The limitation of this study is the exclusion of profitability.

Physicians

Edward A Kazemek

Physician Collaboration

Healthcare Executive, Jul/Aug 2006, Vol 21, Issue 4, pg 54, 3 pages.

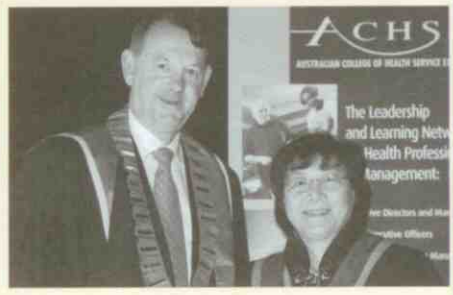
The issue of physician collaboration is a challenging one. From the hospital executives' and board members' perspectives, however, many have reduced it down to one concern - money. However, numerous studies and anedoctal evidence suggest that money is not the only answer and may not even be the most important ingredient in encouraging hospitals and physicians to work together to achieve shared goals. When the board provides leadership to ensure relationships are built and maintained, the chances of success increase dramatically. Money counts, but strong relationships built on trust, candor and fairness mean more. Once boards and physicians focus on their primary goal of providing high-quality care and communicate with each other that this goal is a priority on both sides, a strong collaborative relationship can come to fruition.

Ms Margaret TAY

Past Events

The Power and the Passion -

Joint Congress of the Australian College of Health Service Executives and the Royal Australian College of Medical Administrators



The National Congress "Healthcare – The Power and the Passion", which is a joint Congress of the Australian College of Health Service Executives and the Royal Australian College of Medical Administrators, was a great success. The Congress was held in Hobart, Tasmania, Australia form August 2nd – 4th 2006.

The Congress had a strong theme with a program covering many aspects of the challenges and issues in health care management and was full of interest for all involved in health and aged care management. The Scientific Program was exceptionally good with many high calibre national and international speakers. One of the international speakers who inspired me a lot was Dr. Helen Bevan of the NHS Institute for Innovation and Improvement, UK. Her speech was "A Passionate Vision : the Number One issue on the Minds of Healthcare Executives globally".

Bevan advocated that "Revolutions begin in transformations of consciousness" and said that, at present, prevailing strategies in healthcare rely largely on outmoded theories of control and standardisation of work. More modern, and much more effective, theories seek to harness the imagination and participation of the workforce in reinventing the system. She also talked about the difference between the "Rational" and "Engagement" view for Strategies to enhance productivity in healthcare. In "Rational" views, managers standardise job roles, clinical practice & work process and eradicate waste, non-value adding activities & unnecessary structures while in the "Engagement" views, managers will only create high expectations, clarity of goals, common purpose & establish an enabling environment where people can do their best. The focus of "Rational" strategies will be on doing more with less, doing it faster, better and cheaper. However, the "Engagement" strategies will be



focused on "building, maintaining, protecting trust, the making of work to be meaningful & rewarding, and connecting great results with great values".

Bevan also discussed about the sources of drive and leadership of the change in healthcare from both the "Outside-in" and "Inside-out" perspectives. As far as the "Outside-in" is concerned, managers can learn from the experiences of other healthcare systems and organizations, bring in external experts and consultants to support the change process and also seek out the very best practice & guidance so as to accelerate the change process, avoid reinventing the wheel and create sustainable change. As for the "Inside-out" perspective, executives will create an approach to change that takes account of the unique context & experience of the organization, provide strong, capable internal leadership for the change program, seek widespread buy-in for the changes from key stakeholders, make sure that the internal leaders of the change programmes drive the change, but not the external consultants and ensure a long-term, sustainable perspective.

Finally, Bevan's belief in "Revolutions begin in transformations of consciousness", which should always include:

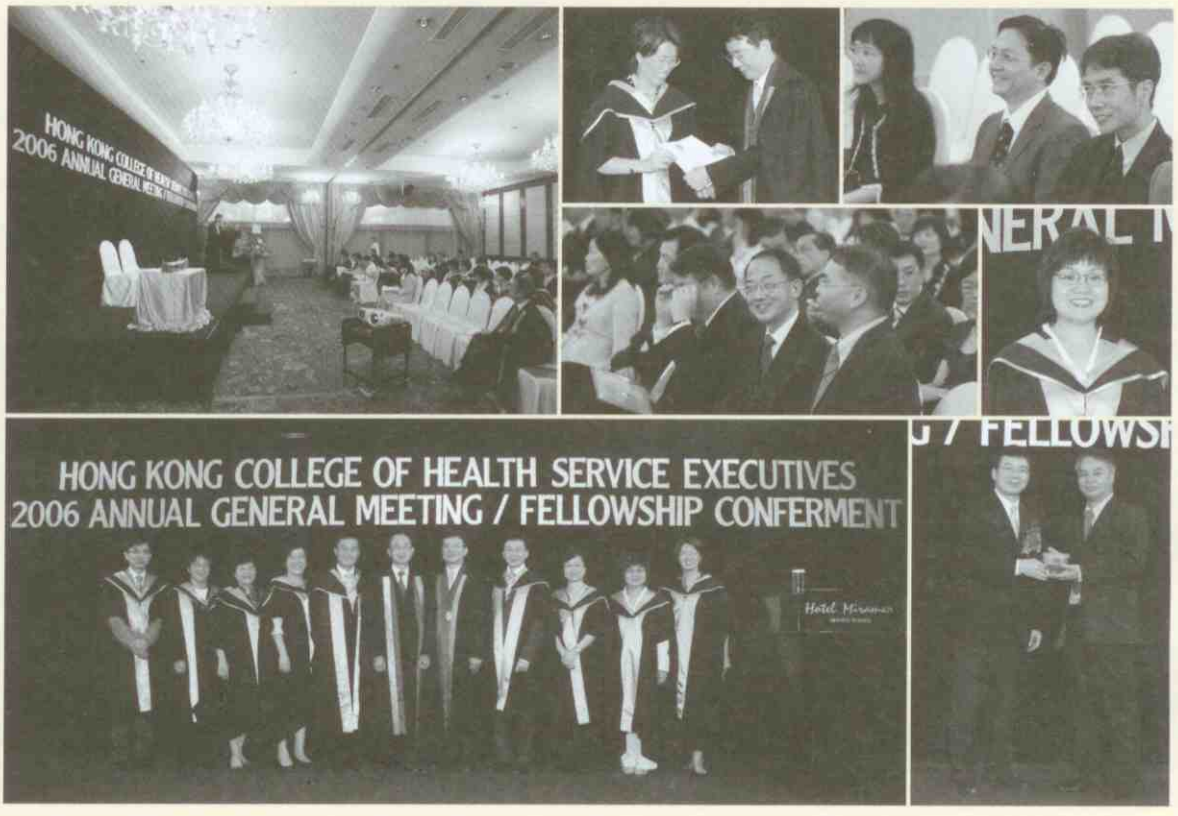
1) Think differently about what we do;
2) Apply ourselves in different ways, and
3) It begins with me.

Mr Anders YUEN

Our New Fellows

Congratulations to the following new fellows of the Hong Kong College of Health Service Executives.

New Fellows List	
Chiang, Sau Chu	Lim, Siew Peng
Chui, Chun Ming, William	Liu, Hing Wing
Ko, Yuk Ying, Susanna	Poon Leung, Kim Lin, Helen
Leung, Kam Ling, Joyce	Tsang Au, Wai Lin
Li, Oi Ching, Rita	Chan, Louis



Title	Chinese Title	Post-Nominal Title
Fellows	院士	FHKCHSE
Associate Fellows	副院士	AFHKCHSE

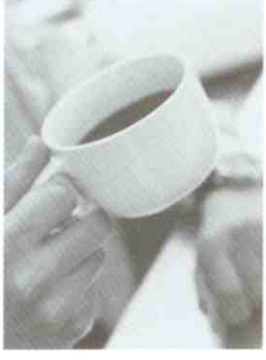
Coming Up Soon

Educational Tour to Guangxi, China

The College will organize an educational tour to Guangxi, China from 8 February 2007 to 11th February 2007. The trip will enhance our understanding of the pharmaceutical and health care industry in China as well as help us appreciate how the cultural and social fabric of a community influences its health care system. Please book early to avoid disappointment!

AGM cum Symposium, 2007

The Council has decided to hold a Symposium in conjunction with the coming Annual General Meeting in 2007. Fellows and members are encouraged to submit papers to the Symposium and to join us to welcome another new batch of fellows to the College at the conferment ceremony during the AGM.



Masters Series - The Art and Science of Chinese Philosophy and Management

Want to know more about Chinese Philosophy and Management, then come and listen to our President, Dr H C Ma who will enlighten you on the science and art of Chinese Philosophy and Management at a series of classes designed to relax your mind after a hard day's work. The dates of the lectures will be announced in due course!

Application Form

Hong Kong College of Health Service Executives

Membership Application / Renewal Form 2007/08

Name (Family Name / other name)

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

Professional Qualification : _____

_____

Qualification in Health Care Management : _____

_____

Work Position Held : _____

Place of Work : _____ _____

(Department / Division) (Organization / Institution)

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

Correspondence Address :

Daytime Contact Phone No. : (off) _____ (mobile) _____

Fax No.: _____ Email : _____

Membership type (please ✓ in the appropriate box)

Membership Type		Annual Fee **		Dual Membership *** (HKCHSE/ACHSE)	
Fellow *		HK$500		HK$2,200	
Associate Fellow		HK$300		HK$2,000	
Associate		HK$200		N/A	

* Fellow membership only applied to those who have been conferred Fellow by the College

** If you are life member of the HKSHSE, 07/08 HKCHSE membership fee will be waived. You still need to pay $1,700 if you want to maintain the membership of ACHSE

*** The council reserves the right to adjust the dual membership fee at the time of approving the membership application/renewal if the currency exchange rate between HK and Australian dollars is substantially deviated from that at early 2007.

Qualification for Associate Fellowship: holding a degree in management or a full time managerial position

Please send this application with cheque payable to "Hong Kong College of Health Service Executives Ltd." to:

P.O. Box No. 70875, Kowloon Central Post Office, Hong Kong

For Enquiry: **http://www.hkchse.org**