Hong Kong College of
Health Service Executives

Newsletter Issue 1 2007/08

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Message from the President

The Health Care Plight of the Middle Class

As far as public health care is concerned, Hong Kong has all along adopted a financing model that depends largely on general taxation revenue of the Government. There has never been any dedicated health care tax or levy collected by the Government. My question is: with this model, who are the main payers of the public health care sector? A simple answer is of course, the income/profit tax payers. However, one must remember that because of the provision of different forms of lavish tax-free allowances by the Government, only those people with annual salary and other incomes higher than a certain level will need to pay income tax. Some clear-minded observers may point out that besides paying income tax, many Hong Kong people are also contributing enormously to Government's revenue through indirect ways. One of this is the very expensive land price leading to outrageously high property value and rentals. But again not everyone in Hong Kong lives in privately owned houses. There are more than two million people of the low-income class enjoying heavily subsidized housing built by the Government. Thus it will be fair to say that the middle and affluent classes are the main payers of the public health care system of Hong Kong.

Message from the President

If we agree with this proposition, then the middle class should also be the ones entitled to public health care services. After all, he who pays the piper calls the tune. However, most of the wealthy will avoid the public health care system which pays little attention to personal privacy and allows no choice for doctors or other expertise. Since they can afford to pay the high fees, they will prefer to seek health care from the private sector. Logically the middle class population has a legitimate right to rely on the public sector as their main health care provider. Here comes the issue: if the middle class people are the major payers as well as legitimate and rightful users of the public health care system, are their needs receiving adequate attention by the Government? Or alternately, are their health care interests well represented in the health policy making process of the Government?

Let us first look at the latest position of the Government on the role of the public health care system. The "Discussion Paper on the Future Service Delivery Model for our Health Care System" drafted by the Health and Medical Development Advisory Committee under the then Health, Welfare and Food Bureau in 2005 stated that the public health care sector should target its service at acute and emergency care, low income and under-privileged groups, illnesses that entail high costs, advanced technology and multi-disciplinary professional team work and lastly, training of health care professionals. There is no special mention of the middle class at all. So if the elderly members of the middle class suffer from chronic diseases requiring long term medical attention and treatment, they are not on the target group list of the public health care sector. In other words they are expected by the government to seek medical care from the private sector even if that will incur significant financial burden to the family. And within the ambit of the four target areas mentioned above, the middle class people still need to pay for very expensive special medications or consumables when they use the public sector if they suffer from certain diseases belonging to the third target group. Many may have to exhaust their assets to get these treatments. It is no wonder why the middle class people feel so upset by the Government's turning a blind eye to their health care needs despite the fact that they are the major payers of the public health care bill.

How about the representation of the middle class at various political platforms that can significantly influence Government policy? Without universal suffrage for the legislature at the present moment, many legislators are wealthy businessmen who do not rely on the public sector for their health care. This is also true for most of the lay directors of the Hospital Authority Board appointed by the Government, who are responsible for overseeing and monitoring the Hospital Authority. Indeed an irony is that many Hospital Authority Board members have never received health care in Hospital Authority institutions. They can hardly empathize with the middle class for the feeling of being neglected by the public sector. It is indeed unrealistic to expect them to pay special attention to the health care interest of the middle class in the deliberation of the strategic directions of the Hospital Authority.

Can the middle class rely on the health care professionals to protect their interest? It is unfortunate that half of the members of the medical profession are working in the private sector. They naturally welcome a public health care system that does not welcome middle class patients and pushes these patients towards them. The remaining half works for Hospital Authority. They get the same salary irrespective of the number of patients under their care or the quality of care they deliver to patients. In other words, there is a moral hazard for the public doctors to prefer seeing less patients resulting in less workload. For the hospital executives, fewer patients using the public hospitals will be better because then the pressure on their hospital budget will be less. Some hospital leaders even embrace the idea that the service quality of the public hospitals should be deliberately lowered in order to avoid patients relying heavily on the public sector. And since the middle class are not that as deprived as the indigents, they could be encouraged to go to the private sector for this reason. This is called the perverse incentive of public health care system. So, health care professionals are also not reliable advocates for the middle class.

One may think that the mass media should be the best ally of the middle class since the latter forms the main bulk of their readership. Unfortunately, most of the mass media workers of Hong Kong are deficient in health care knowledge. They do not possess the required skills to critically analyse health care policies. Nor can they know how to monitor the quality of public health care services meaningfully. Most of them only resort to the use of sensational headlines to bash the public health care sector so as to attract more readers. Very few of them know how to dissect out the underlying causes of health care issues for the benefit of the public. Some even make repeated allegations that they never care to verify. The result is that many middle class people are taken to believe that the public health care sector is in disarray, and should be avoided if one can afford to do so. It can be said that as far as public health care oversight is concerned, the mass media of Hong Kong are counterproductive in many instances and the middle class people are more often misled than helped by them to safeguard their health care interest.

Many patients suffering from chronic illnesses have come together to form self-support groups that serve as watchdogs for the public health care services. Can they be the advocates of the middle class? Unfortunately, their focus is on the exclusive interest of their patient members irrespective of their social class. They will appeal to the Government for more resources to benefit their fellow patients. But they will not (and should not) put the interest of the middle class patients above others. Thus they are also constrained to serve as advocates of the middle class regarding their health care needs.

What else can the middle class do to secure their legitimate claims from the public health care sector? Perhaps it is time that the middle class form an alliance of their own and start bargaining with Government on their stake in public health care services. They should lobby political parties to speak on their behalf in the legislature, and use their strength in numbers and economic influence to demonstrate their clout to the Government. Here I need to clarify my intention in writing this article. I am not urging the middle class to compete against the poor in getting health care benefit from the public sector. No one will object to the statement that the underprivileged should not be prevented from receiving adequate health care because of lack of financial means. The Government has its obligation to take care of them. I am just saying that the existing Government policy on health care is unfair to the middle class. The Government collects its revenue mainly from the middle class to fund the public health care expenditure, but then tries to discourage them from using the public sector by either hindering their access or limiting the coverage for them. In my opinion, this should be changed through more effective advocacy for the health care interest of the middle class in the future health care policy formulation process. However, I am yet to see such a move in this direction up to this moment.

Dr H C MA

2007 Annual Conference cum Annual General Meeting of HKCHSE

21st July 2007 Langham Place Hotel, Kowloon.

Health is a matter that concerns everyone. Health care has evolved over the recent decades into a very complex system with multiple processes and multidisciplinary participation. Health is also one of the most important political agenda items for governments. It is no wonder that health care has so many stakeholders with divergent interests and targets. If there is no consensus among all the stakeholders, no matter how macro that may be, it will be difficult for a community to advance health care further.

As the Hong Kong College of Health Service Executives is committed to making contributions to the advancement and improvement of the health care industry of Hong Kong, it is with this mission in mind that we organize this Annual Conference on the same afternoon of our Annual General Meeting.

To achieve consensus in health care, we need broad participation and a platform that is conducive to effective exchange of views. That is why we have invited Rev. Dr. Raymond C. LEE & Priscilla H. LEE, Chairman and Executive Director, Oasis Hong Kong Airlines, to be the keynote speakers of our 2007 Annual Conference. Dr. & Mrs LEE shared with us how "Innovation & Partnership" have taken place during the establishment of the Oasis Hong Kong Airlines. Their wisdom and experiences are informative and exciting to all the conference participants of that afternoon.

In order to develop a platform that is conducive to effective exchange of views in healthcare of Hong Kong, we have organized two discussion panels for our Conference with eminent speakers that cut across all sectors and major disciplines of health care. We hope that these panel discussions can engender further collaboration among different stakeholders in future.

Finally, we wish to thank all members of the Organizing Committee, who have unreservedly spent their precious time and effort to make this Conference a success.

Anders YUEN

ACHSE National Congress

2007 ACHSE National Congress carried the theme of "Health Innovation – Reforms or Raffles?" was held in Melbourne on 1-3 August 2007.

The Congress was officially opened by The Hon Bronwyn Pike MP, Victorian Minister for Health, timely at her last day in the portfolio following a Cabinet reshuffle. Her honesty for the critical nature of the health and social services portfolio was certainly heightened in her speech.

She was then joined by three speakers at the opening session by:

Prof H Swerisson, Head of the School of Public Health and Associate Dean of the Faculty of Health Sciences at La Trobe University;

Mr Stephen McKernan, Director General of the Ministry of Health in New Zealand;

Ms Dea Thiele, CEO of the National Aboriginal community controlled Health Organization.

All four speakers looked at the 'big picture' scenarios of the need for innovation and reform in relation to the following three key health issues:

Mental Health

Chronic Disease Management

Obesity

The four concurrent sessions in the afternoon were well attended , each addressing the above key health issues, across all health sectors focusing on future direction and strategies.

The Plenary Session on the International Response to Chronic Disease Management and the Lessons for Australia and New Zealand was rated by the writer the best among others. Dr Gary Sinclair put forth a CCM (Chronic Care Management) Model adopted in New Zealand which was well received by the delegates and was perceived by the writer to be of value to Hong Kong situation. The purpose of the Model which was highlighted by Dr Sinclair was to 'shift the accent' in Chronic Disease Management from:

A predominantly, problem focused (often crisis initiated), "doctor dependent" consultation model to;
A systematic model, involving all stakeholders (patients, their families, practice teams and hospital clinicians) in an evidence based, proactive healing relationship with good clinical outcomes. The Model also emphasized the importance of "Proactive Interactions" among stakeholders and "Cultural Competency" as the linking pins for favorable functional and clinical outcomes.

ACHSE Congress Dinner themed "Racing Fever" was again a highlight of the Congress. Delegates were dressed in their finest racing gear and were lining up to bet on the Baxter Cup. The evening was a mix of fun and dancing and a great night for all HK delegates.

Alice TSO

Patient Complaints and Corporate Affairs

What is Complaint?

The word "complaint" has a pejorative meaning to most people. In the healthcare industry, patients do not want to know about the inner workings of a hospital or to hear excuses about why it is difficult to meet their expectations. They simply evaluate the care experience they receive at a hospital on criteria that we as healthcare professionals may not have considered or acknowledged.

To the healthcare professionals, patient complaints are often regarded as unpleasant and as a waste of time and effort. However, looking things from a more positive perspective, complaints are indicators pointing to something which is not working as it should have been. Complaints reflect "real life" situations to the patients, and should not be neglected or ignored.

From the organization of healthcare point of view, the way a hospital manages complaints is a reflection of the quality of its service, and of its desire to retain and satisfy its "customers". In the short run, complaint is a crucial communication tool between the frontline medical personnel and the patients. Patient complaints offer hospital an opportunity to correct immediate problems. In the long run, complaints and complaint trends tell hospital how to do its job better by alerting management to problems, prompting attention and correction. Besides, complaints indicate long range opportunities for service innovation and problem prevention. Complaints frequently provide constructive ideas for improving services, as well as adapting updated standard practices.

Why do people complain?

In the past, patients were unquestioning. Healthcare professionals or managers are too comfortable with the status quo, and too able and eager to justify why a process is the way it is. Some frontline healthcare workers even make their patients or relatives believe that they should not have the right to complain at all.

However, the community is now much better educated and informed about healthcare. Patients are very conscious of their rights. Expectation from the public of the quality of public services has significantly increased. They would complain when their expectations of services are not met, or perceived not to have been met. It would not be surprising to see such an impact given the emphasis of putting the needs of "customers" first on the way public services are provided. Users demanding more of public services, and tolerating less system failure even on trivial matters or minor inconvenience experienced are encountered more often than not. Hence, given the diversity, complexity, and rising volume of patient activities in public hospitals, complaints by patients and members of the public are expected.

Generally speaking most patients or their relatives "complain" in an effort to get answers. Patients believe that they have not received their entitled service, giving hospital an opportunity to correct the immediate problem and restore goodwill.

Why are complaints not taken easily by healthcare professionals?

By tradition, healthcare professionals are trained to help the sick, and to save lives. Therefore, they have a preconception that patients should appreciate that help. Accepting patient complaint on services rendered as a norm is a challenge to the core reason for healthcare professionals to be in the field. In order to strike a balance for these two extreme thoughts, both the rights and interests of patients and staff have to be valued respectively.

Complaint consequences

As mentioned earlier, a complaint made in good faith, or a justified case, can serve as a good reminder to the organization to revisit procedures and practices, discerning systemic issues, and making a difference to the quality of public healthcare services. The potential value of clinical complaints as a means of improving quality of care is also accepted in overseas health care systems (Ref 1). The complaint that goes unreported can be as costly as the one that is mismanaged or unresolved. As a result, what makes the difference is how complaints are handled. If a response to a complaint is timely and accurately addresses the concern, the issue can be resolved before it develops into a more serious action: namely a TORT negligence liability claim or lawsuit.

Complaint handling

In order to cultivate a desired culture, spread of the desired information to each and every corner of the organization has to be enhanced. A fair culture and a transparent atmosphere at work can be nurtured through systematization of incident management. This is where managers come in.

At the macro level, a fair culture can be enhanced by adopting a total quality management approach in complaint management. In other words, each complaint or medico-legal case is managed in the context of quality improvement endeavor, instead of just carrying out a fire-fighting exercise. A safe culture can be developed through regular education and promotion activities. Likewise a proactive culture can be enhanced, with emphasis on learning rather than blaming. In doing so, frontline staff are encouraged to understand, report and learn from adverse events, near misses and errors instead of being blamed on wrong doings.

At the meso level, an organization structure is developed to enhance accountability. Such a management structure should be conducive to two complementary functions, namely

[i] collection of relevant information, and

[ii] quality improvement assurance to timely capture, terminate, and prevent medical incidents. Such a management framework is to integrate risk management with other quality improvement initiatives such as claims, clinical audit, continuous quality improvement (CQI) and occupational safety and health.

The Risk Management Team framework, reporting to the Quality and Risk Management structure, should consist of both the information collection arm (Quality and Risk monitoring), as well as the continuous quality improvement arm (Quality Improvement Initiatives).

The Quality and Risk monitoring arm of the Risk Management Team framework analyzes routinely captured data (collaborating with the centralized Medical Record Office) on critical activities and significant outcomes of care to detect unusual patterns; or anecdotal monitoring data initiated by group discussion or study collected through clinical audits (collaborating with an established hospital Audit Team).

The Quality and Risk Management structure is to derive relevant quality indicators from routine surveillance or specifically analyzed data, to decide on continuous quality initiatives on a regular basis, in relation to the established Quality Improvement Standards.

At the micro level, the workflow of complaint management is stipulated through production of updated guidelines and protocols with regular reviews under a system of monitoring and control to enhance compliance. Hospital frontline staff or, public relation officers, are encouraged to streamline operational issues. This is to ensure that individual patient complaint matters and/or medico-legal cases are handled in accordance with established corporate policies, facilitated by guidelines, protocols and specific job description of any assigned roles in relation to patient relation office matters.

The Patient Relation Office (PRO) is to be under a Risk Management Team framework, which should have mechanism to capture, handle, and report regularly to a Quality and Risk Management structure, incidences of complaint, litigation, coroner cases, and other incidents made known to the Hospital Management through a centralized electronic database if technological advances allow.

In handling controversial patient complaints, the following workflow sequence is one example to take reference from:

step 1 – comprehensive fact-finding, (to ensure staff views and input are duly considered);

step 2 – proper documentation of patient complaints or allegations, investigation findings, observations and conclusions;

step 3 – alignment of Hospital Management standpoint with frontline clinical colleagues prior to responding to complainants;

step 4 – to provide appropriate responses to complainants;

step 5 – to provide feedback to the staff concerned;

step 6 – planning and implementing remedial or improvement measures (if and when necessary). (Ref 2)

Education and empowerment

Having a sound management structure can enhance accountability. However, an organization needs people to carry out tasks according to corporate policy at any one time. Therefore, it is essential to strengthen communication mechanisms in order to develop a common risk management language comprehensible by frontline clinical staff. This attempts to enhance communication and risk identification of potential medical incidents when they have not occurred. Besides, efforts should also be made to regularly conduct educational activities to enhance staff awareness, alertness, and competence with regard to potential clinical risk arena. In order to maximize the spread of key messages among frontline staff, existing communication network as well as innovating effective channels are tapped, to promulgate crucial, essential, topical and relevant medico-legal, quality and risk management issues eg sharing of best practices, Quality Forum or Quality newsletters.

Clinical participation

In order to enhance corporate policy dissemination, active participation by frontline clinical staff is highly encouraged and facilitated. Opportunities are created for frontline clinical colleagues to participate in complaint management processes. An executive partnership exchange programme can be set up, in collaboration with clinical departments, to enable

interested frontline colleagues to be rotated to the Patient Relation Office for attachment officially or, unofficially when clinical commitments of individual staff do not allow full-time attachment.

Furthermore, Departmental Quality and Risk Management Coordinator scheme, having specified roles and responsibilities, can be implemented to facilitate complaint and incident management, as well as coordinating improvement measures in the agreed Quality Improvement Standard compliance context. These Risk Management Coordinators, staff members of individual clinical Departments, can act as ambassadors to deliver key messages to the respective Departments at a most opportune time.

Prevention

Individual complaint handling is important. However, even more important is to systemically study circumstances leading to past complaints. In doing so, system change can be effected to prevent future occurrences of similar complaints by identifying "sentinel events". These events can alert healthcare managers of possible serious system flaws that need to be attended to (Ref 3).

Among the frontline clinical colleagues, management measures can be devised to enhance patient safety. These include proactive self assessment of performance in order to effectively identify, monitor and prevent recurrence of patient complaints and medico-legal incidents. Key service performance indicators can be developed and monitored, in collaboration with individual Department Quality and Risk Management Coordinators, relevant to their respective Departments. Given time, these endeavors are carried out consistently and continuously in the context of Continuous Quality Improvement.

Against the background of performance monitoring, strategic preventive measures, for annually identified top 10 high risk areas, endorsed by the Quality and Risk Management structure, are spearheaded by respective Department Quality and Risk Management Coordinators, in an attempt to prevent future occurrences of similar incidents.

For more serious medical incidents, with potentially wider clinical impact, remedial actions, both immediate and in longer terms, have to be implemented. A sentinel event is defined as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Such events are called "sentinel" because they signal the need for immediate investigation and response" (Ref 4). Conducting root cause analysis by the Clinical Audit Team for sentinel events is another example of proactively preventing future serious medical incidents.

Conclusion

Effective complaint management would significantly help protect patients' right, improve staff morale, and reduce organization risk. With a structure for feedback and accountability, it is more likely for process improvement teams to shift their focus from reactive problem-solving to proactive prevention of problems. Besides, through monitoring and proper follow-up of complaints, we as healthcare managers could all help make significant contribution to patient safety, quality and risk management.

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Quality Patient Complaint Handling – a workflow model. Hospital Authority Convention 2007 Service Priorities and Programmes, 2007:28

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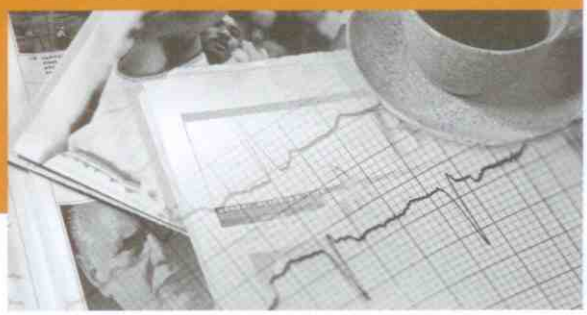
Joint Commission on Accreditation of Healthcare Organizations, USA

Nelson WAT

Journals Update

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



Performance measurement

Taming the Measurement Monster

Patrice L Spath, Frontiers of health services management; Summer 2007,23,4

The health care measurement landscape continues to evolve. Despite questions about the value of performance data, health care organizations are being challenged to meet the data demands of a growing number of mandatory and voluntary measurement projects. Standardization of measure specifications is a real issue and we spend hours arguing over definitions! For most health care organizations, the "measurement" monster needs to be tamed. The author proposes that senior executives must be actively involved in promoting a meaningful measurement system that is compatible with the organization's quality goals and can meet regulatory, purchaser and accreditation requirements. Efficiency must be built into the system collecting the data and expanded information technology support can help reduce the administrative burdens and loading on clinicians. There is no denying that the measurement monster is here to stay and the real value of the measurement system is in knowing where improvements are needed and acting on that information

Leadership

Level 5 leadership: The triumph of humility and fierce resolve

Jim Collins, Harvard Business Review, Vol83(7), July-August 2005, pp136,138-146

A five year research project identified the qualities of a level 5 leader, someone who can truly transform a company from good to great. To put it simply, the level 5 leader is someone who possesses humility and will. He/She acts with quiet, calm determination and at the same time, demonstrates unwavering resolve to do whatever must be done to produce the best long term results, no matter how difficult. But are level 5 leaders born or bred, the author argues that there are some who have the seed of level 5 leadership within them, waiting to be ripened whilst there will be others who can never become level 5 leaders. However, the author did not provide a "ten steps to level 5 leadership" as he believes that the search and quest process itself would perhaps be more enlightening to all who aspire to level 5 leadership.

Health Care Resources

What Should a Country spend on health care?

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

Per capital spending on health varies across countries and regions leading to many people asking the question " What should a country spend on health care" The author argues that to be relevant and meaningful, the question should be reframed as " How much should my country spend on health, given our current epidemiological profile relative to our desired level of health status, considering the effectiveness of health inputs that would be purchased at existing price and taking account of the relative value and cost of other demands on social resources." Hence a simple question has many difficult

and complex answers. The author also discusses the four approaches that can be adopted to answer this question. The first approach is to benchmark with other similar regions. The second approach is the political economy one which addresses the actual political mechanism that determines health spending. The third dimension is to use a production function approach which uses aggregate data to estimate the impact of health spending, socioeconomic characteristics, demographics and other factors on a population's health conditions. The final approach is to find out the health inputs or health services to be purchased to produce the greatest health status changes in a population and to summate the cost of all the desired programs.

Preventing adverse events

Towards an organization with a memory; exploring the organization generation of adverse events in health care

Health Services Management Research, Vol 18, Issue, May 2005, pp 124-140

The role of organizational factors in the generation of adverse events and the manner in which such factors can also inhibit an organization's abilities to learn have become important agenda items within health care. In this respect, the authors examine some of the organizational issues in detail and suggest some strategies that health care managers need to consider as part of their wider strategies for the prevention and management of risks. The authors identified five core elements that are held to be of importance in shaping the manner in which the potential risk is incubated within organizations. These include: 1)Interface between management and medicine 2) incubating the potential for harm 3) sense making in complex situations 4) issues in organization culture and behaviour 5) barriers to learning. The authors conclude that in the final analysis, each organization needs to ensure that it addresses the pathologies within the context of its environment and situational circumstances. Finally, this quote is perhaps worth remembering:

... if we are looking back upon a decision which has been taken, as most decisions in the absence of complete information, it is important that we should not assess the action of decision-makers too harshly in the light of knowledge which hindsight gives." This feeling sums up my own personal feelings of the SARS saga in Hong Kong and the aftermath of it.

Change Management

Facing Change in an Organization: How to chart your way through the chaos

Bonnie Hitch, Healthcare Executive, Sep/October 2005 Vol 20, Issue 5, pg 20-22

" The ability to anticipate change and respond to a wide variety of changes, to bring creativity and imagination to the solutions of problems and to shape and implement personal and organizational strategies to maximize the benefits of change is not an option, it is and will be a survival skill. – John E Sena

Charting an organization through the complex labyrinth of change is a fundamental challenge facing all leaders. This article suggests taking a six-step model to help make the change easier for the organization 1) Determine if the change is needed. 2) Achieve buy in 3)Begin planning 4) Overcome resistance 5) Implement 6) Evaluate. The six step model is circular, ongoing and the status quo is always changing. When you reach the end of the change process, you begin the next round. Isn't this exciting -a Merry Go Round that never stops!

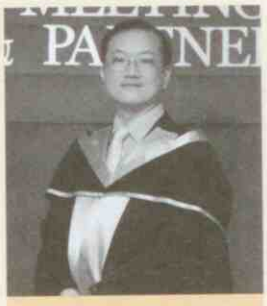
Margaret TAY

Our New Fellows

Congratulations to the following who passed the recent Fellowship examination and were conferred as fellows of the College at the AGM cum fellowship conferment ceremony

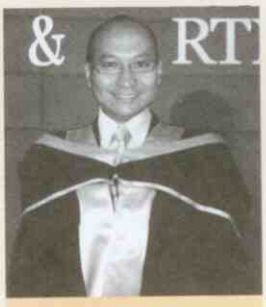
New Fellows List

Stanley Au



Anthony Kwok

Fei Chau Pang



Wai kwong Poon

Ngai Chuen Sin

Tammy So

Neslon Wat

Thesis

It is important that as fellows and members of the College we learn and share with each other. You may encounter a certain problem at work or you may wish to know how others have tackled certain problems. Perhaps you may aspire to be a fellow of our College. Whatever your reasons may be, we encourage you to read the works of our new fellows who have submitted a project thesis for their examination in 2005/06 and 2006/07. You may wish to approach them personally or alternatively, contact our vice President, Dr M Y Cheng for details of how you can access the articles

Here comes the list:

- The challenges of opening a new hospital in Hong Kong and reviewing the hospital performance
- Protecting human subjects in clinical research- From idea to practice
- Safe introduction of new interventional procedures in the Hospital Authority
- Do we learn from disasters? – An analysis of Hospital Authority's response to inquiry and recommendations of two major incidents: Garley Building and SARS outbreak
- Organizing information to sustain service palnning and development for a complex and massive organization- An experience in Hospital Authority
- Building a safer medication management system
- Assisting the implementation of the Hospital Authority drug formulary in the public hospital system in Hong Kong
- The effects on user fee on on-eligible persons utilizing obstetric care in public hospitals
- Establishment of modernized Chinese medicine clinical research and services centre of Tung Wah group of Hospitals – evaluation approach
- The people side of managing changes in healthcare services organization
- What can Hong Kong learn from health care "reforms" in other countries
- The influence of global, political and economic factors on the development of quality health care leading to best practice: Learning from the others' experience
- Development of Chinese medicine service in public healthcare system in Hong Kong
- Communicable disease outbreak management- surveillance, initial response and beyond
- Doctors work hour reform in the Hospital Authority
- Capacity and culture building in the area of infection control
- Assessment of an alternative health care delivery model in diabetes mellitus using a structure-process- outcome framework – Form problem to solution

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:

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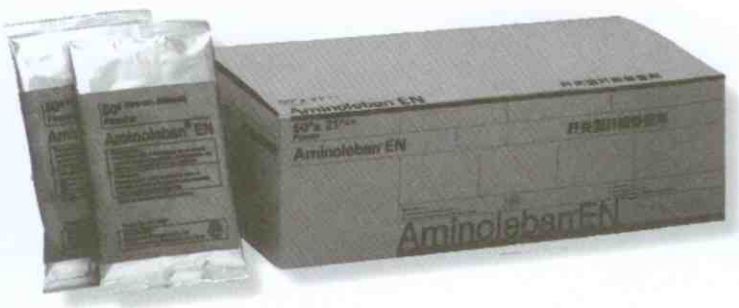
一種專為肝臟病人而製的支鏈氨基酸口服營養品

》在選取支鏈氨基酸的營養品給肝病患者，要考慮臨床醫學研究證明或諮詢醫生意見。



療法：

- 改善血液氨基酸失衡[1, 2]
- 改善肝臟功能[1, 2, 3, 4]
  （例如：提高血清蛋白及降低膽紅素）
- 減少住院次數及縮短留院時間[3, 4]
- 改善病人精神狀況及日常活動能力[1, 2, 4]

劑量：

每日三次或跟醫生指示服用。每次將一包（50克）的肝美靈溶於180ml的暖水（約50℃）中。搖勻後，可供應200k加路里（200kcal）於200毫升的暖水。劑量因年齡及身體狀況而調較。如有疑問，請向醫生指教。

香港大塚製藥有限公司
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Ref. (1) The San-In Group of Liver Surgery: British Journal of Surgery, 1997; 84:1525-1531
(2) Ichida T., et al : Nutrition, 1995; 238-244
(3) Meng W.C.S., et al : Aust. N.Z. J Surg. 1999; 69: 811-815.
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A BREAKTHROUGH IN SMOKING CESSATION

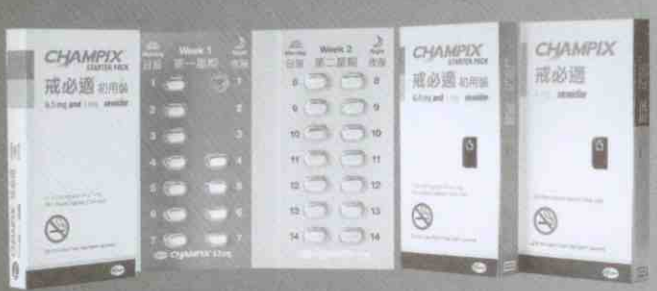
CHAMPIX®
varenicline tartrate
QUITTING POWER

FINALLY, THE POWER TO HELP THEM QUIT

SUPERIOR QUITTING POWER
At 12 weeks in 2 pivotal trials:

4x The odds of quitting smoking with **CHAMPIX** were approximately 4 times **greater than with placebo**
(odds ratios: Gonzales et al=3.85; Jorenby et al=3.85)*[1,2]

2x The odds of quitting smoking with **CHAMPIX** were approximately 2 times **greater than with bupropion SR**
(odds ratios: Gonzales et al=1.93; Jorenby et al=1.90)*[1,2]



In clinical trials, **CHAMPIX** was generally well tolerated. The common adverse events associated with **CHAMPIX** (>5% and twice the rate seen in placebo-treated patients) were nausea, sleep disturbance, constipation, flatulence, and vomiting.[1-5]

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