Hong Kong College of
Health Service Executives

Newsletter Issue 1 2006/07

Inauguration of HKCHSE

Memoirs of the Inauguration of the Hong Kong College of Health Service Executives

After years of hard work and preparation, the Hong Kong College of Health Service Executives was finally and formally inaugurated on May 20th 2005. The event was well attended by guests, founding fellows and members.

Prior to the formal inauguration ceremony, a less formal annual general meeting of the Hong Kong Society of Health Service Executives took place in the same auditorium, albeit, it was conducted in a less formal manner and attracted quite a few laughs as the Chairman conducted the meeting in a brief, lively and almost comical manner.

Outside the auditorium and just before the commencement of the inauguration ceremony, the 60 odd founding fellows were busy gowning up for the occasion. For some, this was a memorable occasion as it would be the first time they put on such an elaborate gown (forgetting the ones they adorned for their kindergarten or primary school graduation ceremony). For others, the act itself brought back many pleasant memories, memories of their graduation ceremony many years ago or when they were admitted to their respective Colleges of the Academy.

As the uplifting sounds of Handel's "The Occasional Oratorio - March" pulsated in the Pao Yue Kong Auditorium, the officiating party comprising of the Guest of Honour, Mr Anthony Wu, Chairman of the Hospital Authority, Dr William Ho, President of the Hong Kong College of Community Medicine, Mr Trevor Cannings, Federal President of the Australian

College of Health Service Executives and all Council Members of the College entered the hall with splendour!

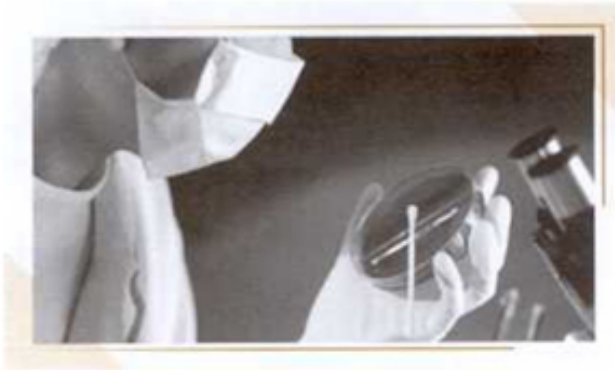
The ceremony was conducted swiftly and efficiently, without a hassle except when I forgot to ask the Founding Fellows to rise from their seats for the President to officially announce their admission into the College. It was embarrassing as the pretty MC had to gesture to me and I was probably "drunk" by the grandeur and the pomposity of the event to even notice that something was amiss!

What a relief when the staccato sounds of " The High School Cadets" rang in my ears and it was time for the ceremony to come to an end. I was ecstatic with joy to know that we have at last, given birth to a College of our own, a College of health service executives which strive to promote the development of professional practice in health service management. It is a proud moment in the history of health care of Hong Kong and I trust that the memories of May 20th will remain with all of us for many years to come.

Margaret Tay

Message from the President

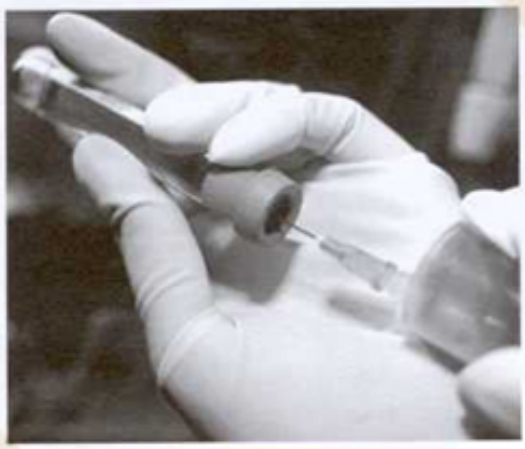
Being a health care professional for more than 25 years, I have never witnessed a health related issue that causes such widespread and immense concern as avian flu. This is also the first time that public health authorities worldwide unanimously and repeatedly issue warnings on the calamitous effect of an imminent public health risk. Apparently it would be "politically suicidal" for any public officials to calm the public by downplaying the danger of avian flu at this moment. Instead most would talk about the worst scenarios that can happen, and emphasize on the importance of preparedness for such scenarios. The situation has now reached a stage of global panic, and there are signs that people are beginning to react irrationally.



This foreboding avian flu pandemic presents some alarming features. Firstly, we have the huge power of the mass media. In Hong Kong, there is virtually no barrier between people and various kinds of mass media. People can learn about almost everything from the Internet. It would be fair to say that most people depend on the mass media for obtaining information as well as knowledge. Unfortunately on the issue of avian flu, most mass media of Hong Kong prefer sensational reports to rational analysis. In many instances, the headlines were eye-catching but misleading, and the comments made were appealing to the people but scientifically unsound. The result is that many people mix up outbreaks of avian flu among poultry herds with those of humans, thinking that there are human outbreaks of avian flu worldwide. Also many people think that the annual influenza vaccination programme for high-risk groups promulgated by the SAR Government can help to prevent contracting avian flu. Some even think that effective vaccines are readily available for humans since the media has reported the vaccination of birds against avian flu in many places of the world where outbreaks among birds were confirmed. Worse still, many people cannot differentiate the different kinds of avian flu infecting birds, H5N1 avian flu affecting humans and outbreaks of human influenza. People (including many health care workers) are not sure if the isolation measures taken by the local public healthcare institutions are for the prevention of outbreaks of avian flu, human flu or all kinds of febrile viral infection. There is little effort by the mass media to clarify these confusions, and pressure on the Government to take effective measures to protect its people only adds oil to the fire. One outcome is that government officials are very much influenced by the opinions of the mass media in their actions.

The second phenomenon is the scarcity of reliable scientific information upon which rational decisions can be made. No one is sure how many types of birds are susceptible to the dreaded highly pathogenic avian flu virus H5 N1. When people ask if wild pigeons could spread avian flu, the health care authorities make conflicting statements. There were even reports that mammals other than humans (tigers and leopards) could be infected and killed by the avian flu virus, without any follow-up by scientific inquiry. Also the worst scenarios are depicted based on models using data from the 1918, 1957 and 1968 human influenza pandemics. We are unsure whether improvements in environmental hygiene and personal protection equipment, knowledge of the patho-physiology of viral diseases, advancements in life supporting technologies, availability of antiviral drugs and the capability of producing effective vaccine against the culprit virus within a certain period after its emergence can all contribute to reduce the impact of the pandemic, or

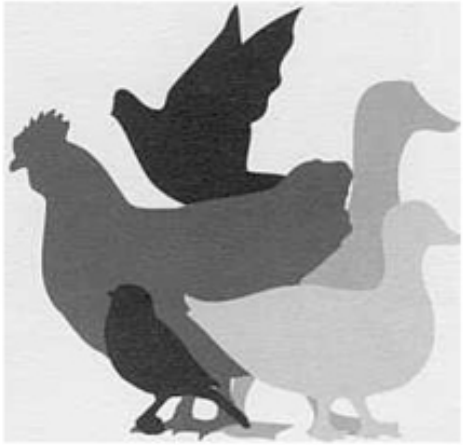
actually abort the formation of the pandemic. There may be mathematical models simulating all these factors, but it is impossible to test their validity under controlled clinical trials. With all these uncertainties, people tend to be pessimistic rather than feeling assured. Thus for government officials it would be at least a safe approach to follow the mass media's demands.



The third observation relates to the breaking down of commonly held values in the face of a live threatening crisis. No one cares about animal rights when avian flu pandemic is concerned, let alone the ecological implications. Rapid culling of all birds within an affected area is a must (but how to define the at risk area geographically is unknown). Also governments are expected by their people to immediately stockpile antiviral drugs without making reference to WHO advice or scientific data. The idea of prioritizing scarce antiviral agents for at risk groups is met with fierce condemnation. There is also no concern about opportunity costs, even if there are real and equally demanding health care needs. If anything can be done to reduce the risk of avian flu outbreak, the commonly held belief is that the Government should do it without regard to ethical or moral concerns. The stake of human lives loss caused by avian flu is so high that the Government should ignore all other considerations, even if utilitarian principles indicate otherwise. For example, if human-to-human avian flu outbreaks occur in countries which lack antiviral medications, our Government is expected to fight for the scarce antiviral drugs for our own stockpiling, instead of helping the affected but deprived countries to obtain the drugs in sufficient amount.

Experts are repeatedly warning that it is about time for another flu pandemic. They make such warning based on the observed periodic nature of these pandemics in the past century. This time they say there is high chance that the highly pathogenic avian flu virus H5N1 will be the pathogen causing the calamity. However, no one can tell how imminent the threat is. The common saying of a cycle of 20 to 30 years actually does not tally with the intervals between the three pandemics. And the variance of up to 10 years is too long a period for the pandemic's cyclical prophecy to be of practical value. Indeed the expected flu pandemic is long overdue! Also most people have no exact idea under which conditions an "antigenic shift" caused by "genetic re-assortment" of the flu viruses will actually happen. We are left with a series of questions: should we be contented with leading our lives under the sword of Damocles like the present moment for an infinite period of time? How long should we maintain our alertness before we can be confident to say that the threat is over and life can return normal with relief? We can be sure of the time when a hurricane or typhoon is over. But for this avian flu pandemic saga, is it true that we can only keep our vigilance and wait for the pandemic to come and take its expected heavy toll? If the time for stand down from our alert is when the epidemic or pandemic finally dies down and we start rebuilding our society from the remaining ruins and mess, what a terrible and depressing thought this is!

Dr H C MA



Hong Kong College of Health Service Executives'

Response to Building a Healthy Tomorrow -

Discussion Paper on the **Future Service Delivery Model for our Health Care System**

I. Introduction

The issue of financial sustainability of the existing general revenue-funded public health care system is attracting more and more public attention. Thus it is timely for the Government to put forward this Discussion Paper for public debate. Unfortunately the report deliberately avoids the financing component of the issue and only focuses on the future roles of various key players and the desirable service delivery model at different levels of health care, with special emphasis on mitigating the phenomenon of public-private imbalance in service share. This renders the Discussion Paper incomplete, undermines the value of the public discussion it aims to initiate, and makes the planning for implementing the service delivery models difficult. Also the report exhibits strong inclination to the medical profession, with total omission of the role of other health care professionals such as allied health and nurses in contributing to build a healthy tomorrow for Hong Kong.

II. Primary Care

We support the concept of promoting the "family doctor" model among the public, and the idea of emphasizing primary and preventive care in the future health care delivery model.

Our Concerns

1. The major philosophy of family doctor is health orientation rather than disease orientation. This may be contradictory to the existing way primary care doctors are rewarded.
2. Not all of the existing general practitioners and private specialists have the aptitude, skills and knowledge to play the role of family doctors to their patients.
3. The public still considers doctor shopping a right thing to do, and the idea of taking responsibility for one's own health is still new to the public.
4. Until we know more about reform in health care financing, there are no obvious financial incentives for the public to take up the family doctor model in preference to the low cost public health care system.
5. There is no exploration on the possible contributions of other non-doctor health care professionals in primary health care. Also the importance of non-health care determinants of health such as education and air quality receives no recognition by the Discussion Paper at all.

1. There must be incentives such that private doctors are willing to support and practice family medicine, promote healthy lifestyles, give health education to patients and prevent diseases by running health screening programmers for patients according to evidence-based cost-effective guidelines. In formulating these incentives, different stakeholders such as the private doctors, private insurers and patient groups should be consulted.

2. To increase the acceptance of the concept of family doctor by the public, there should be mechanism for quality assurance for the private primary health care sector. The competencies of primary health care practitioners should be better defined and their training requirement strengthened. The public should be assured of the provision of good quality and affordable family medicine by competent doctors and that there is adequate information for them to make rational choice of providers.

3. Massive public education by the government with the concerted effort from non-government organizations, schools and media is required to change the value, attitude and behavior of the public regarding correct ways of protecting their own health.

4. The Government should expedite the process of proposing its health care financing models for public discussion.

5. We would like to see other health professionals besides doctors playing a more prominent role in primary health care. Together with the family doctor, they can provide a more holistic and comprehensive primary health care service to the public. For example, community pharmacists can give health education and drug counseling service to their clients, and when indicated, advise their clients to consult family doctors.

III. Hospital Services, Tertiary and Specialized Services

We agree that the Government should better define the role of Hospital Authority, so that it can target its services to those that can benefit most using the limited resources provided by the Government.

Our Concerns

It appears that executives of private hospitals and private specialists have not been included in the Health and Medical Development Advisory Committee. Consequently there is no coverage on their views or roles they might play and how they would interface with the public health sector in the Discussion Paper.

At the present moment the public hospitals are driven by perverse incentives. The more efficient the health care professionals work, the more patients they attract and the more chance their bottom lines go into red. Thus quality services are penalized rather than rewarded.

The shifting of health care delivery focus from hospital to community means that corresponding resources should also be channeled from public hospitals to community-based service providers. But such resources transfer will be strongly resisted by the hospitals that are already desperately in want of more resources for their continuous survival. Any indiscreet redirection of scarce resources for this purpose may jeopardize essential public health care services, such as catastrophic emergency care.

4. The affordability of fees and charges in the private sector and the lack of transparency are always concerns for the patients and their private health care insurers. This is a major obstacle in the transfer of public patients to the private sector and is also a major cause of the public-private health care share imbalance.

   The four focus areas of the public health care service are not mutually exclusive with significant overlap. According to the design of the four focus areas, it is logical to assume that for patients suffering from chronic medical problems (they constitute the majority of patients attending Specialist Outpatient Clinics of public hospitals), public hospital services should be limited to those who are lack of financial means. However, the existing triage method used by the Hospital Authority for prioritizing this group of patients is a clinically oriented one. It focuses mainly on the complexity and urgency of the illness rather than the financial means. Also there is no explicitly defined level of care that the Government is committed to provide for the poor and the under-privileged. This may lead to unrealistic demand for health service by them. On the other hand we also worry that the need for detailed financial means test for most care-seekers to the public health care system may grossly inflate the administrative cost as well as making health care delivery clinically and ethically impracticable.

   The role of the public health care system serving as a training ground for post-graduate health care professionals may be jeopardized if the scope of service of the Hospital Authority is strictly confined to the four focus areas.

7. There is no mentioning of the importance of effective health service management and leadership for making health care reform a success.

8. There is no mentioning of the need for careful and long term manpower planning in conjunction with major health care reform initiatives.

Our Recommendations

1. A broader spectrum of stakeholders should be consulted in drafting the next health care reform consultation paper.

2. Perverse incentive in public hospitals must be curbed. The government might consider creating an internal market in the public hospital system, whereby 'money follows patients'. More efficient and higher quality hospitals should be rewarded for their superior performance.

3. A separate community care-based funding mechanism can facilitate the shifting of care from hospital to the community, so that community health care can be properly planned, staffed and evaluated. Such outlay will be paid back in the intermediate and long term by savings in hospital care.

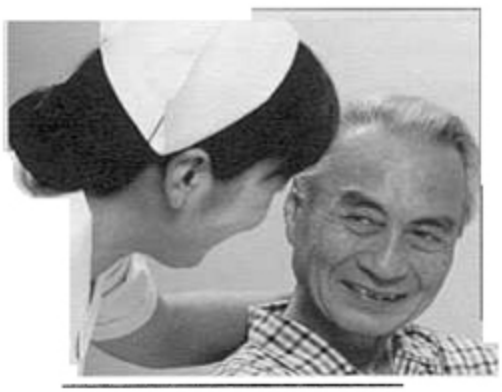
4. To address the issue of public-private imbalance and to protect the rights of consumers in private medicine, the government should introduce some regulations on fees and increase transparency of fee structure in the private health care sector. Of course professional autonomy and market forces should be respected as far as possible.

5. There should be better definition of the four focus areas, especially the scope of service that the Government considers itself obliged to provide for the poor and the underprivileged. However, a simple system of means assessment should be adopted for identifying the poor and needy, and the onus of means test should not be on the doctors to avoid potential ethical conflicts.

6. A mechanism should be in place to ensure that training needs of health care professionals can be safeguarded when Government redefines the roles of the public health care system. Perhaps there should be separate funding for treating patients who meet the needs of post-graduate training of health care professionals.

   The Government should help rectifying the unfortunate perception by the public that health care managers, especially those of public hospitals, are dispensable and overpaid. It would be very difficult for any major health care reform to go along without strong and effective leadership. Indeed there is much need for providing adequate development and training opportunities for health care executives so that they can effectively lead the industry and health care professionals to overcome the challenges related to the inevitable system revamp. A level of recognition and reward commensurate with the level of accountability for health executives will also help attracting talented people choosing health administration as their career.

8 The Government should also avoid using short-term parameters regarding the training of health care professionals, since most of them require long period of training, usually in terms of 3 to 4 years at least. There should be long and intermediate term manpower planning to tally with any major health service delivery model reform.



Fellowship Examination

The Hong Kong College of Health Service Executives (HKCHSE) continues to run a programme that leads to the conferment of Fellowship status by the HKCHSE after a successful exit examination. The training and examination results are reciprocally recognized by the Australian College of Health service Executives (ACHSE). Conferment of Australian Fellowship status will take place at the Annual General Meeting held in Australia together with ACHSE's successful candidates.

Mr Benjamin Lee and myself were appointed as co-chairs for the Education and Examination Committee of HKCHSE by the President and the Council on 16.6.2005. An open invitation was sent out to potential candidates this year and more than 15 senior administrators attended a briefing on 10.9.2005.

Ms Manbo Man led a vetting committee and screened out applications which are now further reviewed by the ACHSE.

In the meantime, the six-month Fellowship Study Group in Hong Kong has begun. Basically, the fellows will assume the role of a leader and as representatives of the HKCHSE & ACHSE, he or she must be an active member of these two Colleges. Having fulfilled the initial criteria, the Council will send invitations to potential applicants each year. A second screening process is set before entry into the training programme, by examining the applicants' contribution to the College, training qualification status in management, experience in healthcare field and research publication. The six-month training serves as the third screening and only successful candidates who have completed the six-month training programme will be eligible to sit for the examination in May each year as the final or fourth hurdle.

Through this programme, we develop leadership and give recognition to experienced healthcare managers from various disciplines. After the Fellowship examination, we continue to have a structured study programme and the group meet regularly to contribute to continuous lifelong learning and advancement of knowledge in the healthcare management field.

Dr M Y Cheng

Trip to Adelaide

With the thoughtful arrangement of Dr Cheng "the school principal" and the enthusiastic support from fellow colleagues, I gallantly sit and passed the fellowship examination in May 2005. Thus, it gave me a good excuse to make a trip to Adelaide for my fellowship conferrment and to attend the 2005 Australian College of Health Service Executives Congress.

The theme of 2005 ACHSE Congress "Partnerships-the Synergy for Reform is not new to us. There were sessions on the private-public interface, reform of health care and Information Technology (IT) development which were also high on our health agenda. With finite health care budget to meet the escalated demand, the public health systems of Australia, Canada and United Kingdom were exploring ways to link up public and private health providers for better service coordination and resources utilization. Although we are miles apart, we share the same views and are heading in the same direction for better health care provision. The exhibition also demonstrated wide application of IT in the health service arena.

There was an episode in the Congress that was worth sharing. A sergeant from the South Australia Police Force was invited to talk about his 14-bullet injury and rehabilitation. After talking for 15 minutes, the sergeant rushed up the staircases to the rear end of the Hall. Turning my head, I gazed in awe that this sergeant was attending to a delegate. Until the Master of Ceremony announced the suspension of the session, I thought it was meant to be a test for us to ascertain how alert we were to emergency.

Including me, there were eight of us attending the congress. Study hard, play even harder. We diligently participated in the enlightening scientific program in daytime; exotic events for the nights. The evening entertainment was varied. One evening, we wined and dined on kangaroo ribs while enjoying the serene river scene. Put on our dancing shoes, we danced away under the alluring music of the Arabian night the next night. We were never idle in the evenings.

Adelaide is a small city, after staying for 3 days, Susanna and I could be tourist guides. We walked our way every day. I must applaud the town planner of Adelaide; the city centre is surrounded by parks.

The 2006 ACHSE is to be conducted in Tasmania, a place in the far south. I look forward to attend the congress and wish that all candidates who sit for next year examination would pass the examination and enjoy Tasmania with me.

Helena LI

Primary Care and Health System Performance: Patients' Experiences in Five Countries 2004

by William C M Chui

Introduction

Primary care stands at the centre of health care systems. Main functions include providing access; delivering medical and preventive care and helping patients integrate care. A comprehensive and quality focused primary care system would improve health outcomes and cost-effectiveness. Ready access to quality primary care also facilitates reduction in inequalities in the health care system, providing opportunities for all to live healthily. In the 21st century, many countries are making efforts to redesign primary care to make health care accessible, seamless, and patient-centred. Health authorities reform their health care system by introducing health promotion and encouraging patient participation in the decision of care.

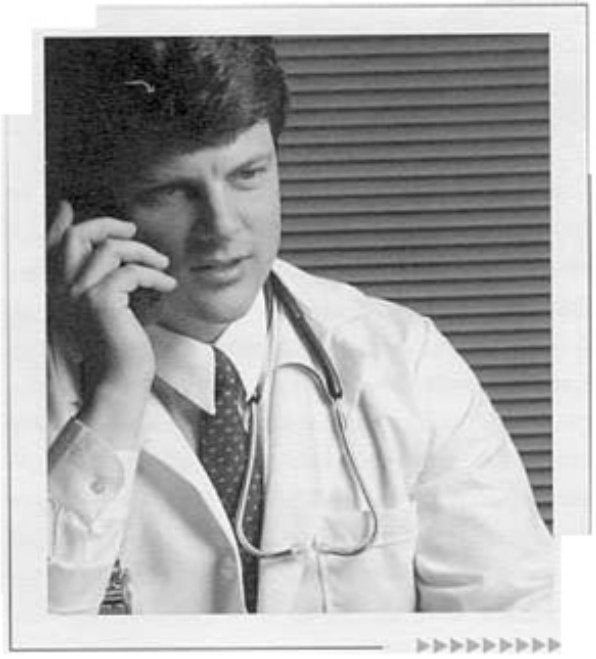
This paper presents findings from the 2004 Commonwealth Fund International Health Policy Survey in Australia, New Zealand, Canada, United Kingdom and the United States. This survey mainly focuses on primary care and ambulatory care experiences.

The survey investigates recent experiences with prescription drugs, access to care, emergency care, preventive care, chronic illness management, coordination, continuity, and doctor-patient relationship. The survey also sought people's views of choice, access to medical records, e-mail communication with doctors and health care system. The survey was conducted by telephone interviews of 1,400 adults ages 18 and older in Australia, New Zealand, Canada, United Kingdom and the United States, with an expanded sample of 3,061 in United Kingdom. Interviews lasted an average of 17 minutes.

Results indicate that there is considerable room for improvement in all five countries on areas of care quality, communication, coordination and engaging patients. Across multiple dimensions of care, U.S. stands out for its relatively poor performance with the exception of preventive care.

Views of the Health Care System

The respondents were asked about system views, confidence, and general cost experiences. The United States stands out as the most negative in overall public views and the United Kingdom as the most positive. One-third of U.S. respondents called for reforms. In Canada and New Zealand, views have grown more positive with a marked decline in the vote to reform. Australia has fluctuated over time. Majority continue to call for major reforms in all five countries. Moreover, in all five countries, only a minority expressed confidence that they will get high-quality, safe medical care when needed.



Access to Care

Having a regular doctor for care with a long term relationship provides a foundation of primary care. The great majority of respondents in all five countries reported not having a regular doctor for care. The United States was notable, with about one-tenth of people having no usual doctor and about one-fifth, no regular doctor. Nearly two thirds of U.K. people had been with the same doctor of care for more than five years, as had the majority of people in Australia, New Zealand and Canada. In contrast, only 37% of U.S. people had such long-term relationships.

For accessibility, the respondents were asked about timeliness, 24-hour availability, and financial access. The majority of people in Australia and New Zealand said that they received appointments the same day the last time they were sick and needed medical attention. While only one-third or less of Canadian and U.S. people reported such rapid access. U.S. and Canada people also reported long waits, with 20-25% waiting at least six days to get an appointment when sick, a waiting time rare in Australia or New Zealand.

Difficulty in getting care at nights, weekends, or holidays was a significant concern in all five countries. The problem was most prominent in the United States. Majority of people in Australia and Canada also said that after-hours access was difficult. The rate of difficulty was lowest in New Zealand, one-third of people views after-hours access as difficult.

If help lines provide a source of primary care access after hours. In U.K., NHS Direct operates a 24 hour telephone nurse advice and information service. If help lines were used most frequently in Canada, U.K. and U.S..

Access concerns were also related to costs. The percentage of people who went without care because of costs correlated closely with countries' insurance systems. U.S. respondents were the most likely to say that they did not see a doctor when sick, did not get recommended tests or follow-up care, or went without prescription drugs because of costs. New Zealand rates of not seeing a doctor followed the U.S. rates and were significantly higher than rates in other three countries.

Lower income people's access to health care was particularly concerned about cost, with problems again the most serious in U.S.

Emergency Room Care

The emergency room (ER) service serves as an indicator for how well health care systems are responding to patients' needs. ER use rates during the past two years were significantly higher in Canada and U.S. that the other three countries. Canadian and U.S. respondents were also more likely to use ER service for a condition that could have been treated by regular doctor if available. Notably, people in Canada and U.S. were likely than people in other countries to report rapid access to doctors when sick and more likely to say that after-hours access was difficult. The results indicate that people of both countries were concerned about timely primary care access.

Long waiting time for ER service was common in all countries. It appears to be a particular concern in Canada, U.K. and U.S.. Australian and U.K. ERs received the highest marks for pain relief. However, more than one-fifth of people in five countries rated the overall quality of emergency care service as fair or poor. U.S. stands out as the most negative with 34% of people rated the service as fair or poor.

Coordination

One-forth or more of people in each country experienced a problem with coordination of care based on three indicators: test results or medical records were not available at the time of an appointment; patients received duplicate tests or procedures; patients received conflicting information; or some combination. U.S. rates were significantly higher than other four countries for at least 3 indicators.

Among those taking prescription drugs regularly, failures by doctors to review medications were frequent. This would increase the risk of drug interactions. High percentage of patients reported that their doctors had not explained the side effects of medications. U.K. people were significantly more likely to report failures to review or explain side effects of medications, but the rates were high in all countries.

16-28% of respondents said that there was a time when they did not receive results or that results were not clearly explained. Rates of delayed results or no explanations of results were significantly lower in Australia and higher in Canada than in the other countries. Moreover, continuity and coordination gaps with primary care also occurred after hospitalization.

Doctor-Patient Relationship and Communication

A vital goal of efforts to improve primary care is to make care more patient-centred. On this issue, the study reveals missed opportunities to identify patients' preferences or concerns, to communicate well, or to engage patients in the decision of care. In each country, people were much less positive about doctors' spending adequate time with them. New Zealand and Australia peoples were the most positive on these issues. Again, U.S. respondents were significantly less likely to rank their doctors highly and the most likely to report concerns.

The majority of patients in all countries except the U.S. and U.K. think that their doctors always make goals and plans clear. Failure to engage patients in treatment plan was frequent in all countries. 30-50% of respondents reported that their doctors do not tell them about treatment choices or ask their opinions. In most countries, at least 20% of patients reported a time when they left the doctor's office without getting important questions answered. A significant share of patients in each country reported a time when they had not followed their doctor's advice, with non-adherence rates highest in U.S.. One of the main reasons for non-adherence was disagreement with the recommendation. In U.S. and New Zealand, costs were also one of the top three reasons. Not taking medications as prescribed was most common in all countries.

Preventive Care

A hallmark of high-quality primary care is a focus on preventive care, counseling and awareness of patients' health concerns. Results indicate shortfalls in promoting health in all five countries. On provision of preventive care, however, U.S. tended to rank high among countries. The study also indicates an overall lack of emphasis on prevention. The lack of patient-centred care extends to those with chronic illnesses. Despite studies indicating that self-management plans are an important component to improving health for people with a chronic illness, one-third or more of those with a chronic condition reported that their doctors did not give plan for self-management.

Provider Choice, Medical Records, and E-mail Access

The study finds that most people are somewhat or very satisfied with their current amount of choice. Respondents reported varying access to their medical records, ranging from a low of 28% in U.K. to a high of 51% in U.S.. Respondents showed interest in e-mail communication with doctor but appeared less widespread than the desire for access to medical records. Among those with internet access but without e-mail access to doctors, less than half in any country wanted to be able to communicate by e-mail with their doctor.

Discussion

Primary care is fundamental to a good quality health care system and plays an important role in health care cost and outcomes. Primary care also influences public confidence in the system. In all five countries, the study found shortfalls in delivering safe, effective, patient-centred, timely, efficient and equitable care. For patients, deficits in accessibility, continuity and coordination add up to poor quality of care experiences. The findings indicate opportunities to take policy action and to learn from countries' initiatives. The risk of medication errors, drug interactions or complications in ambulatory settings also appears high, given that a significant share of survey respondents reported that their doctors failed to review medication or remind them of potential side effects. The study also found deficiencies in delivery of effective care as measured by widespread failure to give patients plans to manage chronic conditions at home. The fact that U.S. performed relatively well on preventive care suggests that policy leadership, clear guidelines and market pressures could make a difference.

Deficiencies in patient-centred care are common in all five countries, based on patients' reports of widespread failure to involve them in treatment decisions and to make goals clear or answer their questions. These communication failures contribute to lack of adherence to medical advice.

Across multiple dimensions of health care, U.S. stands out for its relatively poor performance. With the exception of preventive care, the U.S. primary care system ranked either last or significantly lower than the others on almost all dimensions of patient-centred care. The performance in other countries indicates that it is possible to do better.

Wide variations observed among five countries surveyed suggest that individual countries' policies make a difference. The challenge in all five countries is finding the right combination to improve primary care and ambulatory care and move to a high performance care system. It is important to study international strategies that could be adapted locally.

Application Form

Hong Kong College of Health Service Executives
Membership Application / Renewal Form 2006/07

(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

Correspondence Address :

Contact Phone No. : _____ Fax No.: _____

Email : _____

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)
$1,500 - life member who wish to join ACHSE as well (annual)

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 :

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