The Hong Kong Hospital Authority reform: a historical perspective

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Foreword

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The Hong Kong College of Community Medicine is pleased to present a special edition of a series of articles written by Dr William Ho JP,[1] our Honorary Fellow and former Chief Executive of the Hong Kong Hospital Authority (HA), on the HA's early history as well as his insightful reflections. More than three decades have passed since the inception of the HA in December 1990. At the time, the HA reform was hailed as an unprecedented successful management transformation exercise, galvanising the energy of healthcare professionals to improve service quality by leaps and bounds. Upon leaving the HA in 2005, Dr Ho began writing about this part of Hong Kong's health system's history, from the unique angle and vantage point of a frontline clinician in the pre-HA era, a doctors' union leader involved in negotiations with the Government during the transition period, and subsequently as a medical administrator in the newly formed HA, working all the way to the top position of Chief Executive. His focus was not so much on the detailed chronology of events, but on the socio-economic, political, managerial and philosophical underpinnings that shaped the trajectory of the HA reform.

Today, the organisation is once again approaching a critical point, facing challenges of increasing demand, long waiting times, and staff shortages. Last year, the Government called upon the HA to conduct 'a comprehensive review of the systemic issues and the need for reform with regard to the management of public hospitals.'[2] It is noteworthy that many of the problems currently encountered are not dissimilar to those Dr Ho described in the pre-HA era. Given the passage of time and changes in the environment, many of the original ideas and concepts should be reinstalled in the organisation's memory and laid down as a foundation for future faculty development in healthcare management. From the perspective of our Administrative Medicine subspecialty, such historical material is most valuable for sharing and learning, particularly for Fellows in healthcare leadership roles. We also believe it will have a wider impact on the medical community and even the lay public. Hence, we have discussed with Dr Ho, who has kindly reviewed and suitably revised what he wrote back then, culminating in a trilogy of articles for the *Hong Kong Medical Journal*. We are also grateful to the journal's Editorial Board for facilitating the publication as a special series.

Part 1: From pre–Hospital Authority era to establishment of the Hospital Authority

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This article series, comprising three parts (Part 1 to Part 3), attempts to describe and analyse the early history of the Hong Kong Hospital Authority (HA) reform, from its inception to around the year 2000.

The HA is a huge organisation, second only to the Civil Service in staff size, shouldering the lion's share of healthcare services in Hong Kong. The process of its establishment and the extensive reforms of the public hospital system were most transformational and quite unique in the international scene. Apart from the dramatic service improvements achieved, the underlying management concepts, philosophy and methods were exemplary. Yet, there appears to be little in-depth study on this epic journey, either within or outside the organisation. As time has passed and circumstances have changed, there is a feeling of 'lost organisational memory' in how the HA came about and the underlying spirit of its systems and processes, as reflected to the author by executives and clinicians.

Background to the reform

Public health services in the 1980s

Public health services in Hong Kong traditionally were under the purview of the Health and Welfare Branch of the Hong Kong Government Secretariat, and provided through the Medical and Health Department (M&HD). The Director of Medical and Health Services was in charge of the public health functions and operation of the Government

hospitals. In 1985, 47% of all hospital beds were in Government hospitals,[3] while another 41% were in Subvented hospitals[4] run by charitable organisations such as the Tung Wah Group of Hospitals, Caritas Hong Kong, and so on. The remainder were in private hospitals. While the parent organisations of Subvented hospitals owned the land and buildings, as well as managed these hospitals' operations and staff, the operating costs were increasingly subsidised by the Government, hence the term 'Subvented'. In general, their hospital equipment, staff terms and training opportunities were inferior compared with Government hospitals. Public hospital services were highly subsidised and fees were nominal compared with the actual cost.

Health services provision in the late 1970s and early 1980s generally followed the 1974 White Paper of the Hong Kong Government entitled *The Further Development of Medical and Health Services in Hong Kong*. The main proposals included organising services on a regional basis, building new facilities to cater for the needs of the growing population, particularly in new towns, to achieve a target of 5.5 hospital beds per 1000 population, and starting a new medical school, a new nursing school and a dental school.[5] By the mid-1980s, the system was evidently not coping. One reason was the rapid increase in the population, which grew by 24.18% in the 10-year period after 1974, particularly due to legal and illegal immigrants from Chinese Mainland, and Vietnamese refugees.[6] Serious overcrowding, particularly in the Government hospitals, with the infamous 'camp beds' lining hospital corridors, was a public eye sore. Staff discontent, both in terms of the poor working environment and low morale, resulted not only in a brain drain to the lucrative private sector, but also in waves of union actions.[7]

Vivid accounts of the public hospital scenes at that time can be found in the book entitled *Bedside Manner: Hospitals and Health Care in Hong Kong* by Robin Hutcheon.[8] Observations from people in the system whom he interviewed could be summarised as a severe lack of proper management in public hospitals, poor quality of care, inefficiency in using Subvented hospitals in the system, jealousy over unequal staff terms, and hospital Medical Superintendents being poorly trained for their jobs.[8]

Approach to the reform

International influence

It is to be noted that Hong Kong was not unique in having a poorly run public healthcare service. In the United Kingdom, the government-commissioned *Griffiths Report* of 1983[9] severely criticised its National Health Service (NHS), and recommended wholesale management reform. This was quickly embraced and implemented by the Thatcher government. The United Kingdom's experience then influenced other Commonwealth countries such as Australia, New Zealand and Singapore, where similar reforms were planned for their public health systems. Indeed, managerial reform of public entities to improve performance was the trend of the period in many countries. This ranged from internal management strengthening, corporatisation 'hiving off' Civil Service functions to be run by corporate entities, to outright privatisation. An example in Hong Kong would be the formation of the Housing Authority in 1973 to introduce professional housing management.[10]

Consultancy study

Facing increasing public discontent over the quality of the public hospital services, several legislators pressed for change, including Dr Harry Fang 方心讓, Dr Henrietta Ip 葉文慶, and Ms Lydia Dunn 鄧蓮如. The Secretary for Health and Welfare Mr Henry Ching 程慶禮 proposed calling in consultants to conduct an overall review, which was approved by the Executive Council. The job was eventually awarded to Coopers & Lybrand, WD Scott from Australia, who published their report in December 1985 (the *Scott Report*) [Table 1]. A key recommendation was to take the whole public hospital system away from the M&HD, to be managed by an independent Hospital Authority, free from the constraints of the Civil Service.

At the outset, however, the consultancy study was criticised for its limited scope, which even the consultants themselves admitted in their report. As the pressure at the time was over public hospital services, the consultants' brief was merely to look at how the public hospital system could be improved.[11] This approach of excluding the public health and primary care sides of the healthcare system from the reform proposal sowed the seed for eventual over-reliance on hospital systems and fragmentation.

Such weakness was particularly felt much later during the SARS (severe acute respiratory syndrome) epidemic of 2003 when coordination between the hospital and public health sides was most vital for the success of control.

Political process

Public and stakeholder consultation

The Government conducted public consultation on the *Scott Report* in 1986. Public opinion welcomed proposals on enhancing community participation and the overall objective of management reform in public hospitals, but vehemently objected to the suggestion of linking service fees to a percentage of the cost. Staff working in Subvented hospitals welcomed the proposals, as they expected better pay and a more equitable allocation of resources

TABLE 1. Synopsis of the *Scott Report*

Coopers & Lybrand WD Scott, *The Delivery of Medical Services in Hospitals—A Report for the Hong Kong Government*, December 1985

The consultants identified three key issues that the report would concentrate on:

1. How resources could be more efficiently utilised through integration of Government and Subvented hospitals, measures to improve overcrowding, improve staff productivity and upgrade hospital working environment;
2. How management of public hospitals could be improved through different management structure and systems, as well as alternative staffing methods;
3. How additional resources can be obtained through modified structures for service charges, introduction of higher-class accommodation, and cost control measures.

It went on to recommend several major strategies of improvement.

1. Authority structure
   A statutory Hospital Authority should be set up outside the Civil Service and governed by its own Board with an independent Chairman, but still largely funded by and accountable to the Government. Management of Government and Subvented hospitals should be integrated under this entity. Agreements should be made with the subvented organisations on their hospitals' roles and their participation at the central and regional levels. Such independent structure would be able to improve overall efficiency of use of resources, equalise staff terms among the government and Subvented hospitals, and exercise flexibility in negotiating employment conditions to meet its service objectives while at the same time freed from Civil Service–wide implications.

   Internally, the Board and headquarters of the Authority should concentrate on policies and central functions, while more responsibilities should be delegated to the hospitals. Regional Boards of Management should be established to introduce community input and oversee the coordination of services in the region.
2. Internal hospital organisation
   Each hospital should be headed by a Chief Executive (to replace the former Medical Superintendents who often did not have the power over or respect from the clinical chiefs) who is directly accountable for the overall hospital performance. The Chief Executive should be supported by a Chief Medical Officer, Chief Nursing Officer and Chief Hospital Administrator.

   At the ward level, management of resources should be clearly defined and delegated to the nurses. More senior nursing positions should be created to shoulder the enhanced managerial responsibility. To improve the direct clinical accountability, each clinical Consultant should lead a smaller team and be responsible for less number of beds.

   Clinical departments should be established to bring together the contributions of doctors, nurses, allied health professionals and administrators under an appointed Chairman. Hitherto, big hospitals often had more than one unit of the same clinical specialty which should be combined under a single leadership. In the new structure, the nurses should no longer directly report to the Chief Nursing Officer of the hospital, who is far too removed from the clinical front line, but to the Chairman of the clinical department who is accountable for the quality of care.
3. Overcrowding
   The consultants believed that integrated management of Government and Subvented hospitals, together with improvements in supervision and support to Accident and Emergency Departments, would improve the overcrowding situation in government hospitals. It recommended overflow wards, bed availability information, and a Relative Stay Index as tools to better manage beds.
4. Staff morale
   Conversely, solving overcrowding would improve staff morale, as would improvements in decision making process through shortened lines of communication in the new structure as well as additional promotion posts. Staff from Subvented hospitals would benefit from equalised terms of service, which would also allow greater movement of staff across hospitals. Hospitals should be given resource support to develop their own characteristics and hence staff satisfaction. The consultants further recommended creation of junior consultant positions, and limited private practice for clinical Consultants to boost staff morale.
5. Cost control
   The report called for decentralisation on operational resource decisions to hospital level. It also suggested extension of the existing Ledger Accounting Financial Information System to be extended to major cost areas, and that financial reports should contain output components for monitoring value for money spent.
6. Funding and higher-class accommodation
   The consultants recommended linking of hospital charges to "a small percentage of the cost" of providing service, as well as a host of new charges: attendance charge for Accident and Emergency Departments, first day admission charge, and charges for the use of expensive equipment such as computed tomography scan.

   It was further suggested that higher class accommodation with charges midway between public and private wards should be established as a pilot, and where successful, extended to open up a market for voluntary private insurance. Around 2000 to 4000 such beds might be targeted at.

to their hospitals, even though the directors of the parent organisations feared a loss of autonomy. Civil Servants working in Government hospitals, however, opposed to the proposal, which threatened to cut their existing benefits in order to equalise terms with Subvented hospital staff, and possibly reduce job stability compared with Civil Servants. Nursing unions also opposed the proposed change that would place nurses under the doctors' management in the new clinical departmental structure.

The OMELCO (Office of Members of the Executive and Legislative Councils) Standing Panel

on Health Services, as presented by the then medical constituency representative Dr Hin-kwong Chiu 招顯洸 was generally in favour of the HA proposal.[12] The Governor-in-Council Sir David Wilson 港督衛奕信 announced in his Policy Speech on 7 October 1987 the decision to proceed with the establishment of an HA to integrate the management of all Government and Subvented hospitals into a single system, and to introduce the necessary management reform. To prepare for the change, the original M&HD was to be split into a Department of Health and a Hospital Services Department. The latter would eventually be abolished upon the management takeover by the HA. Meanwhile, a Provisional Hospital Authority (PHA) was to be set up to plan and prepare for the establishment of the HA.

A historical twist

Meanwhile, the public hospital system continued to deteriorate with severe overcrowding, poor environment, long queues, and overworked staff with low morale. The exodus of doctors into the private sector reached a historical high of around 13% for Government hospitals and exceeded 20% for some Subvented hospitals in 1988. Sentiments among members of the Government Doctors' Association (GDA)[13] culminated in a call for industrial action, which was echoed by the The Joint Council of Subvented Hospitals of Hong Kong, and nursing unions. The plight of overworked doctors gained the support of some legislators, such as Dr Che-hung Leong 梁智鴻 and Mr Martin Lee 李柱銘.[14] In a symbolic strike that lasted for 10 days from 1 March 1989,[15] the GDA was able to win over public sympathy and succeeded in pressing the Government to agree to their demand for setting up a high-level committee, comprising representatives of relevant Government branches and departments, as well as GDA representatives. Chaired by the then Secretary for Health and Welfare Mr Brian Tak-hay Chau 周德熙, the committee provided a platform for negotiation and for monitoring progress on promised improvements, without deferring to the yet-to-be-established HA. These included plans to eliminate camp beds, reduce patients' waiting times in specialist clinics, improve linen supply for patients, as well as significantly enhance the salary structure and promotion opportunities for both doctors and nurses. The scale of these improvements within such a short time was unprecedented in the history of the M&HD (Table 2).

From Provisional Hospital Authority to Hospital Authority

The PHA was established on 1 October 1988, chaired by Sir Sze-yuen Chung 鍾士元爵士, a veteran Executive and Legislative Councillor. The PHA adopted most of the recommendations of the *Scott Report* and developed detailed plans. The Government published the PHA Report on 1 April 1990. Legislative processes ensued, and the HA Ordinance was enacted on 1 December 1990, when the HA was formally established, with Sir Sze-yuen Chung at the helm. Most proposed changes were planned for phased implementation, except the proposal to link fees and charges to costs. Indeed, it was written into the HA Ordinance: "*the*

TABLE 2. The high-level committee on hospital services improvement

This unprecedented ad hoc committee, chaired by the Secretary for Health and Welfare, consisted of the following members:
- Director of Hospital Services
- Director of Health
- Representative of the Civil Service Branch
- Representative of the Finance Branch
- Invitees: Chairman and representatives of the Government Doctors' Association

Far-ranging improvement pledges to be followed up in the Committee included the following as announced by the Secretary in the Legislative Council debate session held on 8 March 1989:

(1) On improving patient services
   a. A block appointment system would be implemented in outpatient clinics to reduce waiting time, and a system for keeping patients' records would be introduced to the general clinics.
   b. Supply of patient linen would be increased to address shortages.
   c. Pharmacy service in the Queen Elizabeth Hospital would be extended from 5 pm to 10 pm.
   d. Overcrowding would be alleviated in hospital building programs that would add 23% of beds in a 4 to 5 year-period.

(2) On retention of staff
   a. 32 additional Consultant posts would be created.
   b. 74 additional Senior Medical Officer posts were being created.
   c. A proposal to give an honorarium to doctors in both Government and Subvented hospitals who worked unusually long hours was being considered.
   d. 69 secretarial and clerical posts would be created for the four regional hospitals to alleviate the doctors' non-clinical work.
   e. 205 additional Nursing Officer posts and 591 additional Registered Nurse posts would be created.
   f. Raising the starting pay of student nurses to attract more recruits would be considered.

principle that no person should be prevented, through lack of means, from obtaining adequate medical treatment".[16]

Negotiations with the Government on funding and administrative arrangements turned out to be complex, as more than 20 other Government departments had previously served the public hospitals as part and parcel of their work. Examples included the Architectural Services Department looking after hospital buildings and capital projects; the Electrical and Mechanical Services Department overseeing building services and hospital equipment; the Government Supplies Department handling procurement and inventories; and the Department of Health with its intricate involvement in hospital operations. Once the HA was established, however, it was envisaged that either the HA would have to take over the work or be cross-charged.

Another dimension was the additional resources incurred simply because the HA became a separate legal entity. In the past, Government departments were deemed exempt from many pieces of legislation. However, the HA would not enjoy such exemptions and would incur additional resources to comply with the myriad requirements of various ordinances. The Government agreed to allocate additional resources for the HA to purchase necessary insurance policies, licences and registration fees. Nevertheless, the full implications of these requirements could not be easily appreciated from day one.[17]

There were also negotiations with staff unions on new HA terms of employment and 'bridging-over terms', as well as with the boards of directors of Subvented hospitals, which proceeded in earnest. For the latter, it was agreed that ownership of land, properties, and equipment would continue to belong to the parent organisations, including any subsequent Government investment in hardware upgrades. It was also agreed that nominations from the parent bodies would constitute the majority in future Hospital Governing Committees.[18] Formal contract signing with all 15 Subvented organisations that governed 23 hospitals in the system took place on 24 May 1991.[19] In a 'big bang' approach, the HA took over the management of all 38 public hospitals and 37 000 staff overnight on 1 December 1991.[20]

Thus, it took merely around 6 years from the conception of an independent HA, to 1 December 1990, when the HA was formally established, and another 12 months for the HA to take over all operations of public hospitals. Given the scale of public hospital services and the enormity of major changes to be implemented, this was a most successful feat, even by international standards. Such a result could be attributed to congruence with prevailing societal values and concerns, as well as major stakeholders' interests. An attempt to explain these factors is made below.

Analysis

Societal value system

Hong Kong as a predominantly Chinese society first and foremost embodied the traditional values of communitarianism and the Confucian care-based ideology of good government, particularly in healthcare.[21] At the same time, Hong Kong, as a British colony for more than a century, had inherited much of the British system in its social structure. The public healthcare system was similar to the British NHS, with centralised bureaucratic control, funded entirely through general taxation, and with all doctors employed as salaried staff. The ideology was similarly one of egalitarianism, where the stated Government policy was that every citizen had the right to appropriate public healthcare when sick. This spirit was eventually written into law, as mentioned above, namely "*no person should be prevented, through lack of means, from obtaining adequate medical treatment*".[16]

However, unlike the NHS with its framework of General Practitioner gatekeeping, Hong Kong did not have a well-developed public primary care system. Instead, there existed a large private sector in which patients typically paid out of pocket for treatment. Under such a 'dual system', people could afford private care for minor illnesses, while most depended on the public system for hospital services.

Such a value system explains:

a. The vehement community opposition to even a hint of linking public hospital charges to a percentage of the cost.
b. The relative tolerance of the Government's decision to focus reform efforts solely on public hospitals, rather than clinics, even though no one would consider the services in Government General Out-Patient Clinics to be any better.
c. The general sympathy for overworked hospital staff, given that patients' lives were at stake.

Stakeholders' interests

Any major reform has to address the interests of key societal stakeholders. The state of affairs at the time can be summarised as follows:

a. Public: While the majority of patients with severe illnesses depended on the public sector for the highly subsidised care, there was widespread discontent over the poor state of public hospitals in the early 1980s. Change for the better was, in fact, long overdue.
b. Staff: Doctors and nurses in the system were increasingly frustrated by overcrowding and poor working environment. They deeply felt the constraints of stifling bureaucracies, where obvious problems were left unaddressed. Manpower shortages worsened as experienced staff left for the private sector in growing

numbers.

c. Government: There was evidence that the Government was equally concerned about system-wide inefficiencies and the limited management capabilities in the M&HD. At the same time, while the Government was increasingly funding the Subvented hospitals, it felt it lacked a commensurate level of control over their operations.
d. Subvented organisations: There was a strong sense of second-class treatment among Subvented hospitals, particularly in terms of staff conditions, equipment, and funding compared to Government hospitals. Any reform aimed at levelling these disparities would be welcomed. Although the respective boards of directors feared losing autonomy under the new HA, such concerns were outweighed by overwhelming staff support for change.
e. Politicians: The interests of Legislative Councillors largely coincided with those of the public. Moreover, there were 'functional constituency' legislators at the time, including one seat for the Medical constituency (elected by registered medical practitioners) and another for the Health constituency (elected by other healthcare professionals). There were also appointed members with medical backgrounds. Their expertise in the healthcare field often gave them considerable influence in related debates.
f. Professional bodies: The Hong Kong Medical Association was all along supportive of public hospital reform, in light of the plight of public doctors who formed a considerable part of its membership.[22] The same applied to nurses' unions, particularly The Hong Kong Association of Nursing Staff and the Nurses Branch of the Hong Kong Chinese Civil Servants' Association, as well as other bodies such as the Association of Hospital Administrators, Hong Kong.
g. Business sector: The business sector generally welcomed any Government initiative to improve public hospital services, viewing it as beneficial for societal stability, economic development and the health of the workforce. Moreover, a high-quality, heavily subsidised public hospital service would also indirectly benefit private businesses by helping lower the premium of health insurance they needed to provide for employees.
h. Private hospitals: Private hospitals only constituted a small portion of the market share for hospital services, as most people could not afford private care and fewer than half of the population had any meaningful private health insurance cover at the time. These hospitals also operated as separate entities without a united front and thus did not exert much political influence.[23]

Epilogue

As described above, the 6 years from the initial conception to the formal establishment of the HA were by no means straightforward and guaranteed. Political determination by the Government was paramount, while leadership from legislators, community organisations and staff bodies was also instrumental. Equally important, the buoyant economy of Hong Kong at the time helped support such bold reform, which predictably had major resource implications. Be that as it may, this was only the first step in the journey. Part 2 will describe how the HA undertook the mammoth task of reforming the public hospital system in its initial years, based on the blueprint established thus far.

Declaration

The author declares full responsibility for the accuracy of the content, which does not represent the views of the Hospital Authority. Given the scale of the reform, not all aspects can be covered in detail. Interested readers and scholars are encouraged to consult the Hospital Authority's publications for further information.

Acknowledgement

This article series is based on an unfinished project from the author's time as a visiting fellow at the Harvard School of Public Health, aiming to document both the history and philosophy of the reform. The author is grateful to two successive Presidents of the Hong Kong College of Community Medicine, Dr Libby Lee and Dr Fei-chau Pang, for encouraging its revival.

Notes

1. The author was Chief Executive of the HA from 1999 to 2005. He was initially trained as a specialist in general surgery and worked in the former M&HD. Upon the establishment of the HA in 1991, he joined the HA Head Office to assist in the management transformation process, and thereafter worked in the operations team in various positions. He was appointed Hospital Chief Executive of Kwong Wah Hospital from 1995 to 1999, before being further promoted to head the entire organisation as Chief Executive.
2. Hong Kong SAR Government. Secretary for Health deeply concerned about management of public healthcare system [press release]. 21 Jun 2024. Available from: https://www.info.gov.hk/gia/general/202406/21/P2024062100808.htm. Accessed 1 Sep 2025.
3. Coopers & Lybrand WD Scott. The Delivery of Medical Services in Hospitals—A Report for the Hong Kong Government. Hong Kong: Hong Kong Government Printer; December 1985. Section 3.1.
4. These hospitals, originally established as private institutions, became increasingly dependent on Government subvention for financial sustainability over time, hence the term 'Subvented hospitals'.
5. Coopers & Lybrand WD Scott. The Delivery of Medical Services in Hospitals—A Report for the Hong Kong Government. Hong Kong: Hong Kong Government

Printer; December 1985. Appendix 3A.
6. Coopers & Lybrand WD Scott. The Delivery of Medical Services in Hospitals—A Report for the Hong Kong Government. Hong Kong: Hong Kong Government Printer; December 1985. Appendix 3B.
7. Ng A. Medical and health. In: Tsim TL, Luk BH, editors. The Other Hong Kong Report. Hong Kong: The Chinese University of Hong Kong Press; 1989.
8. Hutcheon R. Bedside Manner: Hospital and Health Care in Hong Kong. Hong Kong: The Chinese University of Hong Kong Press; 1999: 34-42.
9. National Health Service Management Inquiry. Griffiths Report. London: Department of Health and Social Security; 1983.
10. Hutcheon R. Bedside Manner: Hospital and Health Care in Hong Kong. Hong Kong: The Chinese University of Hong Kong Press; 1999.
11. Coopers & Lybrand WD Scott. The Delivery of Medical Services in Hospitals—A Report for the Hong Kong Government. Hong Kong: Hong Kong Government Printer; December 1985. Section 1.1.
12. Official Report of Proceedings of the Hong Kong Legislative Council. Session held on 15 October 1986. Hong Kong: Legislative Council; 1986.
13. The author was Vice Chairman of the Government Doctors' Association in 1989 and actively took part in negotiations with the Government. He became Chairman in 1990-1991.
14. Official Report of Proceedings of the Hong Kong Legislative Council. Session held on 8 March 1989. Hong Kong: Legislative Council; 1989.
15. The main action that achieved the aim of embarrassing the Government without adversely affecting patient care was the refusal of public doctors to sign the payment slips for discharged patients, who were discharged anyway but without the need to pay up. The other actions—refusing to teach nursing students, attend non-urgent medical boards, and write non-urgent medical reports "because the doctors were too busy"—were essentially cosmetic, with little real impact during the short period.
16. Hong Kong SAR Government. Hospital Authority Ordinance (Cap 113), Section 4(d). Hong Kong: Hong Kong Government Printer; 1990.
17. Indeed, the HA was haunted years later by stipulations in the Employment Ordinance that certain staff unions claimed the organisation had violated, due to the long working hours of doctors—the subject of a lawsuit that lingered until 2006 over matters dating back to before 2000.
18. The HA also promised to honour the traditions and philosophies of the parent organisations. Examples included service restrictions (such as abortion) in some religious hospitals, and the traditional Free Medical Service provided by the Tung Wah Group of Hospitals (TWGHs) for out-patients. With these concessions, the HA was able to reach agreement first with the TWGHs, which owned five hospitals. Once this was accomplished, the other subvented organisations soon followed suit.
19. Following enactment of the HA Ordinance, these hospitals became known as Schedule 2 hospitals. Schedule 1 hospitals comprised all former Government hospitals previously under M&HD.
20. Such a feat was rarely seen elsewhere. Singapore, for example, reformed its public hospitals one at a time.
21. Tao J. Confusion care-based philosophical foundation of health care, In: Leung GM, Bacon-Shone J, editors. Hong Kong's Health System: Reflections, Perspectives and Visions. Hong Kong: Hong Kong University Press; 2006: 41-60.
22. The Association's stance changed considerably a few years later, due to concerns that a "too successful" HA posed a threat to the business of its private sector members. It complained of an "unequal playing field" as the HA was able to offer services that were equal to, if not better than, those of the private sector, while being heavily subsidised by the Government. However, this was not foreseen at the time.
23. The Hong Kong Private Hospitals Association was not established until as late as 2000.