HONG KONG HOSPITALS

- THE GEOGRAPHICAL IMPLICATIONS OF A HOSPITAL PHILOSOPHY

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Abstract

The pressures exerted on hospital facilities in Hong Kong from an ageing population with increasing expectations, are compounded by a continued growth in population. Hospitals have clearly failed to deal with rising demand and, as a consequence, are commonly perceived to be in a state of crisis. In this respect, most comment has centred on the overall quantity of provision and quality, as assessed largely in terms of technical care and hotel conditions.

This thesis highlights the additional issue of the spatial inequality of provision in a rapidly changing urban scene. In extending discussion to the "appropriateness" of new hospital provision, the thesis examines the relationship that hospitals have with their client populations. This involves not only their geographical location, but also their interaction with other health care providers in the urban space and, most importantly, the roles which hospitals have been assigned.

The thesis explores the link between the function of a hospital and the principles on which the hospital system is based, arguing that the system is not merely a product of a particular politico-economic setting, but also of a history of influences, not least of which has been the need to mediate between the diverse cultures and traditions of Hong Kong.

Guiding principles concerning the role and functioning of hospitals can be collectively described as a "hospital philosophy". Because it has arisen out of diverse influences, such a guiding philosophy may be susceptible to change, even though basic economic and political relations remain essentially unaltered. Since a hospital philosophy can affect location decisions and the way in which the hospital interacts over space, any change in philosophy may have spatial implications.

The thesis assesses the extent to which the philosophy can be successfully altered from within the system by paying particular attention to the relationship between one hospital, which has proclaimed an alternative approach, and the area which that hospital serves.

Also examined are the Government's own plans for changing the operation of hospital services for the 1990s and their spatial implications, assessing to what extent this reflects a significant change in outlook towards hospital care.
Acknowledgements

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Finally, gratitude is expressed to all those at United Christian Hospital and the Kwun Tong Community Health Project who gave so much of their time to share their enthusiasm and vision; to the community nurses who put up with me on many home visits; and to all the workers in other organizations and the Hong Kong Government who were prepared to meet me, be questioned and offer their views.

This thesis was finally completed at the Chinese festival.
of Ching Ming - a time when Hong Kong families descend on the countryside to sweep the graves and honour the dead. It was the mourning for the deposed Premier Hu Yaobang a year ago that started the historic events in the centre of Beijing. As the crowds occupied the great square in front of Tien An Men - the Gate of Heavenly Peace - hopes in Hong Kong 2000 kilometres to the south soared. A China, more in tune with their aspirations seemed, at last, a possibility. The night of June 3rd/4th changed all that.

In the immediate aftermath, a million Hong Kong people took to the streets. Since then, many thousands have made their last trip to Kai Tak Airport. Making full use of medical imagery, the Hong Kong press talks of emigration being once a "weeping wound", becoming now a "fatal haemorrhage". The sadness is that so many of those stimulating and energetic health workers who I spoke to in my research, no longer work in Hong Kong.

This thesis is dedicated to those who stay.

Andrew Paterson,
London,
3rd April 1990
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Introduction

Throughout the 1980s, the Hong Kong press, often equating "health care" solely with "hospital care", has portrayed three main concerns in Hong Kong's 34 public hospitals:

- extreme overcrowding in hospitals, resulting in poor hotel standards and tight rationing of professional time;

- an absence of specific facilities and types of technology;

- recruitment and retention of staff, especially doctors.

A visit to an Accident and Emergency Department, through which, significantly, the majority of hospital admissions are made, or to a specialist out-patients department, can involve hours of discomfort, standing and queueing in unsatisfactory conditions.

News reports have cited examples of 15 camp beds in a 34 bed ward at 1970s-built Princess Margaret Hospital and wards at the older Queen Elizabeth Hospital where camp beds "almost equalled" official beds (SCMP, 8/11/83). Occupancy rates at all the major acute general hospitals are unremittingly high. In some hospitals, figures are distorted by the policy of admitting all head injury cases (if necessary on camp beds) for observation regardless of severity of injury, itself, a defensive
response of doctors beleagured by threats of litigation.

It is significant that so much press comment has centred around the medical profession. This reflects partly on the profession's ability to present its case for public attention and the public's readiness to accept medical doctors as the key actors in the type of hospital care that is demanded. Much of the publicity has also resulted from tensions that exist in Hong Kong, between the medical profession and a bureaucracy that has always striven to keep them in their place.

Staffing problems are chronic. Whilst it would be unrealistic for Government to attempt to match very high incomes commanded by specialist doctors in private practice in Hong Kong, pay cannot be regarded as unduly poor. Ostensibly, working conditions have been at the fore of professional complaints, as was made clear by the 600 doctors present at an unprecedented mass meeting in late 1988 and at which pay issues were not raised. A recent survey of Government doctors has revealed that 16% of the 440 respondents were intending to leave Government service in the forthcoming year. Of these, 33% had more than 15 years experience (SCMP, 3/9/88). The wastage rate of doctors from some public sector hospitals has been as high as 23% per annum (SCMP, 20/10/88). To meet losses of doctors in the past, Hong Kong has imported on average about 150 doctors per year, mainly from India, Burma and
China. Consequent language problems (including amongst ethnic Chinese), traditional racial tensions and the variable quality of the recruits, create additional difficulties in the clinic or on the ward.

What have been described as "appalling work conditions" (SCMP, 7/10/88) are coupled with very poor career prospects in rigid hospital hierarchies. For instance, in the whole of the public hospital service of nearly 25,000 beds, there were in 1988, less than 20 consultant anaesthetic posts. Perhaps the only way up for the aspiring doctor is out. For the doctor trained in modern technological medicine, the failure of Hong Kong hospitals to keep adequately abreast of technological developments elsewhere, presents additional professional frustrations as s/he confronts a public with heightened expectations and suffering from the diseases of the post-industrial 20th century.

With the uncertainty over Hong Kong's future post-1997, emigration erodes at staffing levels of all types of professional workers in the hospitals. There have been increasing difficulties in recruiting school leavers for nursing, who in a full employment situation, can find easier, if less well paid, employment. A third of the beds at the newest psychiatric hospital, Kwai Chung Hospital, have at times been unoccupied due to staff shortages (Hong
Importing nurses from the Philippines has been suggested.

Hong Kong's hospitals are thus portrayed as being in a state of "crisis". But no single breaking point has been reached or even identified and it is questionable whether, at least before the increased emigration sparked off by the Tien An Men massacre of June 1989, the situation was any more serious than it has been for many years. Whilst there are clear grounds for criticising health care provision in Hong Kong, it is important to keep in mind the context of a rapidly growing and now ageing population in a developing city that has experienced a radical epidemiological transition (Phillips, 1986). Account must also be taken of the achievements that have been made. It can be argued too, that the issues are far more complex and long-lasting, and that the solutions are less tangible than, as commonly demanded, increased capital and recurrent expenditure. For one, there will always be a "need" to spend more and given the economic and political circumstances, resources will always be limited, even if the Government decides (or is able in the face of constraints) to spend substantially more of the GNP on health care. In heated media discussions, in Government responses to criticism and in professional contributions to the debate, there has been a confusion of issues. The media has encouraged separate campaigns for a specialist
children's hospital (e.g. SCMP, 29/11/87) and for improved renal dialysis facilities (e.g. SCMP, 24/11/86) which have further obfuscated the picture. Confusion is hardly surprising, given the complexity of problems in any modern hospital system (especially one which has had to cater to a very rapidly increasing population) and the vested interests of those employed within it and of certain groups who seek specific services from it.

In Hong Kong, two generally held assumptions do seem to have gained widespread acceptance. One assumption is that hospitals can, and should be, viewed in isolation from other aspects of the health care system. A second assumption is that much of the answer to overcrowding lies in the provision of more hospital beds, and preferably, more hospitals. Indeed, Government planning and publicity in the health care field, has until recently, revolved almost exclusively around bed numbers. Since 1986, whilst still referring frequently to what might more accurately be described as "paper beds" (beds planned for some, often uncertain future time and for which resources have not been allocated), the Government has also sought managerial solutions, the results of which will be seen in a major re-organization of the public hospital service in the 1990s (HK Govt, 1986a).

These assumptions lie behind the Government's continued expansion of hospital services and obscure finer
consideration of the appropriateness of such investments. This thesis argues the need to look deeper. There is a need to consider what hospitals are really for, in what ways they are used and why, in a modern, prosperous and rapidly developing city, people put such unremitting strain on expanding hospital facilities.

In the words of one commentator,

"The types of hospital which we build, faithfully mirror our attitudes to life and death, illness and health: faithfully reveal in mud and wattle or bricks and concrete what man believes about himself, how he understands life, suffering and death; and how he responds to illness, whether by curing, caring, banishing or seeking to probe its causes" (Wilson, 1975 p7).

Attitudes and beliefs influence the tasks a particular hospital is assigned to perform. Through history, these tasks have varied. Reflecting the Latin origins of the word, hospitals have at times, acted simply as hostels. They have also functioned as prisons, asylums, welfare agencies, places to await death and places to receive therapy. In this present age of technological medicine, therapy is accorded the predominant function, although in practice, the modern general hospital may still fulfil any one or more of these traditional roles.

Roles may be responses to needs. In health care, needs tend to be ill-defined (demand being an imperfect reflection of genuine need). "Needs" are really perceived needs and evaluated by those in positions to make
decisions. Roles will also reflect the guiding principles that underly the building and operation of hospitals. Guiding principles of particular interest to the geographer concern the ways in which hospitals aim to relate to the population they serve, as well as the ways they approach the human problems with which they deal.

One particular hospital in Hong Kong, which professes to operate in ways at some variance to the norm, has publicly declared its own "philosophy". This is a term that has been used, albeit loosely, in other contexts (see e.g. Paine and Siem Tjam, 1988 and WHO, 1987). In the sense that it has been used, a hospital "philosophy" is a collective description of the beliefs, rationale and objectives that underly a hospital's functioning. There are difficulties in identifying such philosophies. In some instances, as with the Hong Kong example, there may be published statements, but in general, principles are less likely to be consciously articulated as a coherent body of thought and belief. Clues may have to be sifted from the vast and increasingly complex modern hospital machine and from the social, economic and political environment in which it functions. Ideas do not float freely of the socio-political context but that does not necessarily mean that they are determined or produced by the constraints this context exercises. In exploring the notion of the hospital "philosophy", this thesis assesses
the extent to which choice, a process that ideas can encourage, is a practical issue, given the constraints that exist. In other words, is it justifiable to view constraint more positively as, to borrow a term from Foucauldian discourse theory, "conditions of possibility"?

An outline of the thesis

The factors that are felt to have influenced the development of hospital philosophies are dealt with in Chapter 1. Use is made of a framework that recognises the importance of the politico-economic setting, presenting as it does, not only certain exigencies, but also so many constraints. However, it is argued that the political economy cannot be the only consideration. In developing the idea of a "philosophy", an attempt is made to balance the dominance given to the political-economy, both explicitly and implicitly, in much of the literature and to explore the possibility of variation within particular politico-economic systems. It is argued that hospitals develop from a complex history of influences. Influences include developments in technical understanding and practice which have in the latter part of this century, created tensions with the less tangible interpretations of "health".

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Ideas and influences permeate from outside the system and these are received or interpreted in different ways by participants within. Thus, variants to the established "philosophy" may be expressed, although to what extent they can succeed in the face of the prevailing attitudes awaits assessment in later chapters. Variants may have implications for the location and operation of hospitals over space. In particular, the attitude towards the service area can be highlighted as a major philosophical variant. Discussion centres on the stated philosophy of the above-mentioned hospital, the United Christian Hospital in Kwun Tong in eastern Kowloon (also dealt with in depth in Chapter 4) and the spatial possibilities of its stated approach to its service area.

In Chapter 2, use is made of the framework suggested in Chapter 1 to examine the factors that have led to the development of the prevailing attitudes towards hospital provision in Hong Kong. This seeks to set the politico-economic factors in the context of, amongst other things, cultural factors and the subsequent role of colonial government as a mediator between east and west.

A number of key aspects of the ways in which Hong Kong hospitals function are identified and along with evidence of stated aims a picture of aspects of a prevailing philosophy is produced. These aspects reflect responses to the key considerations that distinguish the alternative
philosophy proposed by the United Christian Hospital such as attitudes towards client access, public involvement, perspectives for evaluation, determinants of resource use, managerial styles, external and internal aspirations as well as, fundamentally, the role of the service area. It is not the intention necessarily, to present the prevailing hospital philosophy of Hong Kong as anything particularly unique, although it is felt that, whilst some of the aspects may be manifest elsewhere, they may appear in Hong Kong in a somewhat extreme form. The aim is to show how the philosophy has developed from a fuller framework of factors than simply those determined by a capitalist system.

Chapter 3 relates the aspects of philosophy identified in Chapter 2 to the spatial characteristics of the Hong Kong hospital system. The size, location and interaction of hospitals is considered and particular attention is paid to the role (or the "non-role") of the service area. A retrospective examination is made of the development of hospitals in Hong Kong in which phases can be identified during which the prevailing philosophy appears to have gained ascendance. The most recent phase of hospital development has centred around regionalization of services and this is given attention especially with regard to the role of the service area. In this, comparisons of regional provision are highlighted as are the characteristics of
facility distribution within regions, both of which reflect prevailing Government ethos. The chapter concludes with detailed case studies of the processes that led to the location of two major hospitals to be constructed in the late 1980s and 1990s relating these to the constraints that exist and assessing the extent to which, realistically, choice was possible.

Expanding on issues raised in Chapter 3, and relating back to the initial discussion of Chapter 1, Chapter 4 comprises a detailed study of the operation of United Christian Hospital and its interaction with its consciously defined service area. It is argued that its philosophical stance, at variance to the Hong Kong norm, has affected both its location and its relationships with its surrounding space. In addition to a detailed survey of community health activities based on the hospital, the chapter also discusses the evidence of utilization of the hospital produced as a result of an analysis of in-patient data. An assessment is made of the extent to which the success of this initiative and philosophy has to be qualified by the hospital's existence within an overall health care framework that has little empathy with its stance.

Finally, in Chapter 5, Government proposals for the future development and management of hospitals in Hong Kong are critically appraised in the light of the prevailing
philosophy and its weaknesses, forcing a return to the original questions concerning what hospitals are actually for and why people continue to need to use them so much. In concluding on the validity of the concept of a hospital "philosophy" as an aid to understanding hospital service provision, the chapter views the future for hospitals in Hong Kong in the light of the continued constraints that exist.

The geographical perspective

This thesis sets out to be, in essence, a geographical study. Urban hospitals exist in the space of the city. They are the foci for the many thousands of patients, outpatients and visitors passing through their doors each year. With the exception of asylums, which may be deliberately isolated, hospitals are usually integral parts of the urban system. Hospitals represent major capital investments in the urban fabric. In Hong Kong, they consume areas of land that could otherwise house thousands of people and have proved expensive in terms of lost land and other revenues. For instance, the small and now obsolete British Military Hospital occupies prime residential land currently valued at over £400 million (SCMP, 7/10/88). In Hong Kong, a typical acute-general hospital may employ up to 4000 workers, many having to travel to the site each day. It will be a major consumer of resources, ancillary services and supplies which may be
sought from the surrounding area. In addition, hospitals are significant importers of goods, services and as seen, importers of specialist labour.

The hospital may be important, not only for its functions, whatever they may be interpreted as, but also for its existence as an important and recognisable place in the urban space. And the hospital is a vital place. It is a centre for crises, from major disasters and epidemics to individual, family and personal events. The hospital is not only a centre for trauma but also a place for reconstruction and new life, a place of pain and joy. Life begins in hospital for nearly all Hong Kong-born citizens and for 81.5%, of those who die in Hong Kong, life ends in hospital too.

It is possible that there are other aspects of the perceptions of the hospital as a place such as the connection with the perception of area or locality. Areal identity and allegiance may be confused in a high density, highly mobile urban area such as Hong Kong where formal political involvement, at any level, is restrained. In such a rapidly urbanizing situation, with large inward, outward and intra-urban movements, communities may be difficult to identify in the geographical sense.
Individual perceptions of place and area are influenced by past and present socialization through the use of language, symbols and common experiences. In Hong Kong, a setting for the meeting of major cultures, there is a wealth of cultural norms to guide attitudes. This may lead the public to a "consensus identity" of place derived through common and shared experiences as well as a more superficial and readily changeable "mass identity", the product of opinion influencers such as the media (Relph, 1976). In Hong Kong, the media influences by both criticising hospitals, as has already been seen, and also nurturing an underlying mythology of hospital care and a confused set of expectations of what a hospital is and what it should provide.

Although influenced by political, social and economic circumstances, the media do not necessarily act with any coherent motive or plan. Largely, they promote and in so doing, strengthen, ideas born outside their mechanisms. With regards to the space of the city, they provide, as Relph has argued -

"a simplified and selective identity for places beyond the realm of immediate experience of the audience and hence tend to fabricate a pseudo world of pseudo places" (Relph, 1976 p58).

The stage at which the Hong Kong hospital ceases to be a "pseudo world" and becomes a "real" place must vary between personal circumstances. As has already been suggested, in the modern technological hospital, much that
goes on is inaccessible to the comprehension, knowledge and even recognition of the lay person experiencing it.

Other geographical considerations - location

Both location of hospitals and the nature of their service areas are concerns of this thesis. If it could be assumed that location was solely affected by economics, it might be possible to analyse hospital location on the basis of locational efficiency. However, the classical theory of industrial location, whereby the optimum location is decided by balancing variables of costs and profits, is not really applicable. For many hospitals, maximum revenue generation and even the minimization of costs are not the prime objectives. Rather, the goals will be "to maximise some benefit or minimise some cost to society as a whole" and this may be difficult to quantify (Eyles and Wood, 1983, p. 122).

Clearly many factors other than locational efficiency affect hospitals in the public service. Contemporary land availability (an extremely important factor in Hong Kong), political pressures and the perceived geographical distribution of "need" are but a few. This thesis will assess the argument that whatever the factors, they are interpreted and decisions made in an overall philosophical framework and this can influence the final location chosen. This can apply whether decisions are made on an ad
hoc basis (as they certainly were in the past) or more on the basis (at least nominally) of some professed strategy or overall plan.

Hospital locations are the result of decision-making processes at particular points in time. Once chosen and the investment made, the site will continue to be used, even if locational factors change. There is a marked inertia in hospital locations. Thus, present locations may represent decisions made a century or more ago and consequently, philosophical frameworks that have since been superceded.

**The service area**

In simple spatial economics, a service area would be defined by the distance that clients would be prepared to travel (the "range") to a central place in order to obtain the service provided. The order of service provided by a central place is determined by the threshold that can be sustained by the populace living within the range. In the simplified model world of the isotropic plane, where services of a particular order are equal in stature and where access is the product of free decision, service areas might be expected to fit together in the hierarchical, hexagonal market areas of Christaller's Central Place Theory. This idea may superficially appeal
to geographers, attracted by the recognition that the key organizational attribute of the modern health care system is also hierarchical, given the degree of specialization in medicine and the consequent division of labour and resources between institutions (and therefore locations). If such locational modelling were possible, it could have great utility in accounting for the evolution of particular hospital patterns and also as a tool for planning.

Unfortunately, the complexities of the real world also complicate the picture of the service area. Since Christaller-type ideas are based on notions of profit, central place theory has to be modified greatly if it is to be of any assistance (Mayhew, 1986). As suggested already, in state- or insurance-funded health care systems, there are few "market signals" to allocate resources or to regulate supply and demand. Additionally, health care services are frequently found to generate demand, so that it becomes difficult to assess the extent that demand reflects "genuine needs". Other weaknesses cited by Mayhew (ibid) include the complexity of variations of population density across the space of the city and the fact, that in transport terms, and therefore in terms of physical accessibility, the urban landscape is nothing like an isotropic plane. To this list can be added the fact that in health care, the location of facilities at different levels in the hierarchy may be connected (e.g.
GPs locating near hospitals) and that due to the control of access through referral systems, proximity to a facility in itself, may not enable access (Joseph and Phillips, 1984).

Perhaps the greatest contribution that a purely economic concept of the service area has made is in emphasising the consumer, albeit a consumer with a fairly one-track mind. This emphasis is a useful geographical heritage, although, as geographical studies on utilization have shown, a far more searching examination of consumer behaviour and attributes is required in order to reveal rationales for use of medical facilities.

Utilization and the service area

Utilization has been a major concern of medical geography. Utilization is assumed, with good reason, to be associated with access. Indeed some geographers have described utilization as "revealed accessibility" (e.g. Joseph and Phillips, 1984). Physical access must have important implications for the nature of the service area. This has long intrigued geographers, who when studying health care provision, have always to contend with the fundamental problem that consumers are distributed unevenly but continuously across the urban space, whilst services are almost inevitably provided at discrete, fixed locations.
The notion that use declines with increasing distance from facility (a "distance-decay" which can be related in economic geography to the concept of "service range") is a logical expectation which can be observed especially in a rural context where transport is poor (see e.g. Smith 1977, for application of this in Uganda where it was found that the distance patients are prepared to travel is affected by the order of the service offered). There is some evidence that it can also occur in urban settings as seen in emergency department attendance in Toronto (Ingram et al, 1978). A study of utilization in Hong Kong has argued that distance-decay might still apply in a high density urban situation (Paterson, 1977) and a more up-to-date examination of this is included in Chapter 4 in an attempt to relate utilization to service area boundaries.

However, urban areas more often show that physical distance is but one determinant of actual access to the hospital. Many other factors will affect utilization, both in situations where there are choices of facility and even when no other facility is available. For instance, age, sex, ethnicity, social class and income are known to be important in varying circumstances and these may relate to spatial distributions across the city although in Hong Kong, the high density of population tends to make spatial distinctions difficult to observe.
No matter how sophisticated the analysis, by looking at the impediments to utilization (or the factors that encourage it), the tendency is, as Chapter 1 explains, to look at the relationship between hospital and service area as a "centripetal" one, in which the necessity is to bring people into the facility. This is a fundamental reflection of the philosophy of hospital care. An alternative philosophical viewpoint might regard the relationship with the service area in a far more "centrifugal" manner. In this, the hospital might view its responsibilities towards the service area in a more expanded way (perhaps taking into account some of those considerations that affect utilization) and working to lessen the need for the population to travel to the hospital in the first place.
Conducting the research

The choice of Hong Kong as a location for study, stemmed from the researcher's familiarity with Hong Kong gained through growing up and working in the colony. The research was conducted between late 1984 and mid-1988 on a part-time basis in non-employment hours and during holiday periods. This researcher's full-time employment as a teacher, at first in west London and then between 1986 and 1988, in Kuala Lumpur, Malaysia, restricted the times in which in-depth field work could be performed. In all, three fieldwork visits to Hong Kong were made, but none of these trips exceeded five weeks. This time restraint and the subject of the enquiry necessitated an eclectic approach to a variety of methods and approaches which are summarised below.

1. Use of existing literature on Hong Kong

Recourse to existing literature served a number of purposes including background familiarisation and the identification of areas not yet covered by academic enquiry. Not surprisingly, social aspects of Hong Kong have been much researched. Many Hong Kong analysts, tend to allow idiosyncracies and an obsession with the unique to obfuscate basic economic and social forces at work.
Apart from crude Marxists such as Easey (1972), who sees the Hong Kong situation ripe for revolution prevented only by a repressive state, and an isolated attempt to relate health care reform in Hong Kong to capitalist social relations (McDermott, 1986), analysts are generally reluctant to use established theoretical bases. And yet they fail to provide alternative theoretical explanations of Hong Kong society.

This is seen clearly in Miners' standard constitutional review (Miners, 1977). England and Rear (1975), in their examination of Chinese labour conditions under British Rule, also fail to set their work in a coherent theoretical framework despite being conscious of the operations of the Hong Kong capitalist system. Jarvie and Agassi's pioneering sociological collection draws attention to Hong Kong's "intrinsically interesting features and its own special problems" in the absence of any stated encompassing framework (1969). Harris (1978), in his colourful exposition, argues that few analyses "can touch Hong Kong, for Hong Kong suggests a portmanteaux of paradoxes". Harris asserts that Hong Kong life embodies the various philosophies of Confucius, Sun Yat-sen (who received his medical training at Hong Kong's first western hospital) and Mao, as well as Adam Smith, Christ and Darwin, although no one single philosophy can be said to dominate. Recent publications of collected works on the changes in Hong Kong society (Cheng, 1984; Kwan and Chan,
1986) are simply collections, interesting and valuable though they may be.

There is one notable exception to this absence of theoretical analysis and that is Lau's key text - "Society and Politics in Hong Kong" (1984) - to which substantial reference is made in Chapter 2). This develops a theory of "familial utilitarianism" and the mediation of the colonial Government at the interface between Chinese society and the western society.

Whilst the spatial aspects of health and health care are not well catered for, there is a diverse and growing body of literature on health care beliefs and behaviour in Hong Kong, particularly that examining traditional Chinese practice. (see e.g. Lee, 1980 and 1983). The historical perspective is also quite well treated with Choa (1981), Paterson (1987), Li (1974) and Mattock (1984) being useful sources on past facility provision and which have been referred to especially in Chapters 2 and 3.

Much of the information about health behaviour in Hong Kong is, not unexpectedly, derived from structured questionnaires. This is not only a popular approach in academic work in Hong Kong, but also in market research and increasingly in media opinion polls (e.g. SCMP, 1/12/86), and also in academic health behaviour
investigations. There are advantages of this kind of work. Such questioning reduces interviewer bias, enables the collection of apparently accurate data in large quantities which can then be aggregated, cross-matched and from these, generalizations made. The emphasis on standardization also facilitates comparability (Moser & Kalton, 1979).

Phillips (1984) for example, used such questionnaires to investigate the use of primary facilities in Shatin New Town as did Tan et al (1984) who compared illness behaviour in a village and a housing estate. Kleevens and Lam (1982), after experiencing poor responses to both door-to-door and mail surveys, resorted to telephone questioning (a favourite method in Hong Kong market research) in their pilot study of morbidity in Hong Kong households. Lee (e.g. 1980), the most prolific writer on health behaviour in Hong Kong, has made extensive use of questionnaire surveys. Ho, in her work on dietary beliefs in health and illness, also in Shatin, made use of a formal questionnaire to gain household information, although the dietary beliefs were assessed with a more flexible attitudinal rating system (Ho, 1985; Ho and Donnan, 1985).

All of these surveys have produced useful information, although sometimes few conclusions seem to be drawn other than to confirm what has long been expected in illness
behaviour and attitudes in Hong Kong. The temptation with such surveys has been to attribute a high degree of importance to every finding. Some of the conclusions arise out of extremely small samples. Tan et al (op cit) considered that a sample of only 25 village households and 25 estate households was sufficient; Longstaff-Mackay and Lo (1985) in their study of AED cases of wife battering used a sample of 50; Li et al (1985) in their study on breast feeding habits interviewed 80 mothers. Additionally, there is a danger that persistent cross-tabulation can lead to the production of quite spurious associations.

An additional misgiving about structured questionnaires comes from aggregating individual responses into seemingly uniform categories and then assuming that the reasoning behind the aggregated responses is also uniform. Bateson (1984), challenging the nature of information gathering through survey work, is uneasy about the general lack of theoretical grounding to the whole process of "data construction" (a term he pointedly uses in preference to "data collection"). He argues that in using the informant to gain access to the social world, the informant becomes an "adjunct" to the researcher. The informant is not an "expert". S/he merely has a store of everyday knowledge, presumably sufficient to meet the needs of everyday life. The researcher may require a far higher degree of expert
knowledge, whereas the knowledge that is being tapped in
the informant has been accumulated in an unsystematic and
incidental way to meet the informants own needs to
completely different standards of accuracy. This is a
highly concrete level of knowledge.

The knowledge aspired to by the researcher may be far more
abstract and will inevitably deal with generalizations
which are abstract constructs. Possibly, in cases where
the subject matter is very "factual" or "straightforward"
the formal response is appropriate. But how "factual" is
information about health behaviour? As will be discussed
in Chapter 1, "health" is not an objective quantity. It
involves subjective meanings and experiences that are
constructed by participants in a social setting and these
may colour even the "facts".

An alternative to structured questionnaires is found in
more open-ended questioning which avoids making
generalizations from isolated responses as it is not
seeking the same kind of "accurate" order out of the chaos
of reality. The need for this was recognized in the work
by Kleevens and Lam (op. cit.) who deliberately allowed
interviewees to ask questions and to elaborate on health
matters as long as they wished, but has not been used that
extensively in other studies.
2. Observation on home visits

The visits were made in the preliminary stages of the thesis research. In all, visits were made with nurses from 6 community nursing bases in Kwun Tong, East Kowloon, to over 50 homes in a variety of housing settings. Detailed observations were made on 31 visits.

Although these observations did produce some quantifiable information, this was not the main intention and, given that it was not collected on the basis of random or systematic sampling (the researcher was the guest of the community nurses who showed him what they felt were interesting cases), plus the general dissatisfaction with small sample sizes that this researcher has expressed above, reference to the findings is made either in passing, where it is felt they might add to points already being made, or as "case study" information.

Essentially, the purpose of the visits was to strengthen the researcher's personal understanding of the living and environmental conditions in the study area of Kwun Tong (i.e. the service area of United Christian Hospital, see Chapter 4), and to learn more of the operation of the community nursing service itself, as it has been proposed that this service could contribute to a solution to the so-called hospital "crisis" (see Chapter 3), providing the hospital philosophy permitted it. It would have been difficult to even consider the arguments for and against
early hospital discharge without some examination of the very crowded and generally poor housing conditions that prevail. Additionally, accompanying nurses gave some subjective view, at any rate, of what it is like to be a community nurse in Hong Kong, with some understanding of workloads, travel time and prospects for care outcome. A flavour of some of the situations is captured in selected case studies at Appendix C.

Visits provided much opportunity to talk with nurses and in so doing, points raised in the health behaviour research already conducted in Hong Kong (such as that relating to doctor-choice, referral seeking, traditional medicines and hospital utilization) could be clarified with reference to home situations. The visits also gave opportunity to talk to some of the clients and their carers.

Ideally, perhaps this might have led to long open-ended conversations to explore feelings about health care, facility access, choice of hospital and so on. The realm of informal interviewing is a complex one. The attraction is the belief that the informal interview can dig deeper and thereby presumably gain a richer understanding of the individual's thinking. However, Moser and Kalton (op cit) point out that this does not necessarily mean that a fuller response is any more valid than a simpler answer.
Many individuals have few hidden depths to explore—they live their lives in a world of simple solutions and simple replies. This was often noticeable on home visits. Additionally, some respondents were senile, mentally handicapped or stroke victims unable to speak.

In the event, other problems militated against long interviews. Firstly, the qualifications of this researcher were inadequate—the language barrier and the dependence on the nurse as a translator for all but the simplest responses prevented a spontaneous discourse. On a few occasions, the nurse herself experienced problems with dialects of clients. Secondly, the actual time available for talking about things other than those directly pertaining to the illness, treatment, progress and prognosis, was limited. Community nurses are extremely busy people. Although some visits were lengthy (lasting over half an hour), the time was fully occupied with nursing activity. Exercising stroke victims, for example, is an extremely time-consuming and exhausting activity.

Despite these problems, brief conversations were possible. Before the visits started, the researcher and the nurse discussed a checklist of questions which were raised during the subsequent visits and which served as a spring-board for conversation. This meant that on each visit, clients were asked about their decision to use United Christian Hospital and if applicable, their
referral route; their use of GPs and traditional medicine sources locally and their knowledge of the hospital's community health project's health centres.

With the main purpose being observation it is valid to consider briefly the types of observation possible ranging from "complete participant" (where the purpose of observation is secret) through "participant-as-observer" and "observer-as-participant" to that of "complete observer" (where the observer is isolated in an eavesdropping role) (cited in Burgess, 1984). On two isolated occasions, the researcher was clearly mistaken as a doctor and so achieved complete participant status. On most encounters, the client or their families regarded the researcher as "observer-as-participant". On two occasions, the researcher gave assistance in exercising CVA victims, and so could have been classed as "participant-as-observer". No outwardly expressed resistance to the presence of this researcher was detected and the response was generally welcoming and hospitable.

3. The use of documentary evidence

The use of documents (published or unpublished, official or unofficial) is an effective form of research that is possible to do away from the field, which in the circumstances of this researcher was important. Whilst
extremely useful, documentary evidence must be used with care for the reasons listed below.

Firstly, documents evidently contain bias, although so long as this bias is acknowledged, this should not be a major obstacle. Indeed, in this study, the stance revealed by documents was often the most important revelation and the reason for examining the documents in the first place.

Secondly, the use of documentary evidence is inevitably selective, with the researcher making recourse to only those documents that have survived or have been located, or which s/he has chosen to locate and use. It is not really possible, as in other research approaches, to use methods such as systematic or random sampling to guarantee an unbiased selection of evidence. Some degree of balance can be achieved through a disciplined access to documents of opposing camps, however.

Thirdly, official documents, such as government reports, may not always convey the atmosphere of the context in which they were created. Unofficial documents may be more likely to reflect the mood of their creators (especially if of a campaigning nature), whilst newspaper reports and comments, of which this research makes appreciable use, may concentrate too much on atmosphere at the expense of other information. Details of documentary evidence used in
In this research, the access afforded by one personal contact to, what were at that time, restricted papers of the official Medical Development Advisory Committee (MDAC) and not generally in the public domain, provided a very valuable insight into official thinking. Substantial reference is made to these committee papers, especially in Chapters 2 and 3, where a more critical assessment of the outcome of such committee work is also given. Other official documents used have been those published by the Medical and Health Department or by the Secretary for Health and Welfare. Three key publications have been used as a basis for discussion of policy making over the years - the 1964 and the 1974 White Papers on Hospital Development (HK Govt, 1964; HK Govt, 1974) and the more recent so-called Scott Review on the future of hospital services (HK Govt., 1986a). In addition to these, the annual reports of the Medical and Health Department (e.g. HK Govt, 1987a) have provided not only a comprehensive epidemiological record, but also a detailed breakdown of hospital services, beds available and specialities, facilitating much of the discussion in Chapter 3. Additionally, statements by the Director of Medical and Health Services in these reports can provide some illumination on Government health care policy.
For population data on the Territory-wide and hospital region scale as well as at the level of the specific case study (Chapter 4), census data were used. The main sources used were the main report of the 1971 Census (HK Govt, 1972); the 1976 By-census reports (HK Govt, 1977); the main report from the 1981 Census (HK Govt, 1982a) along with more detailed breakdowns for Kowloon and New Kowloon (HK Govt, 1982b and 1982c) reports from the 1986 By-census (HK Govt, 1987b and 1987c).

b. Unofficial documents

The unofficial documents that have been used were largely unpublished or those duplicated for limited circulation. These included the minutes of meetings. For instance, the minutes of the planning committees for a joint church hospital for a decade from 1960 provided the basis of the study on the location of United Christian Hospital in Chapter 4. Discussion papers for internal circulation within the United Christian Medical Service provided much of the basis for discussions on the United Christian Hospital's philosophy in Chapter 1. Papers produced by the Kwun Tong Community Health Project were invaluable in describing its functioning (Chapter 4) whilst internal memos and evaluation reports, provided indication of the organization's problems. In another context, campaign articles from the Eastern District Hospital Coalition were used in conjunction with media sources and official
Government statements in the discussion of the location of an Eastern Island hospital in Chapter 3. In addition to these more "atmospheric" papers, extensive use was made of regular statistical bulletins and reports at United Christian Hospital, to which access was generously given.

c. Newspaper reports

A separate word is needed on the use of newspaper reports. Day-to-day government in Hong Kong appears to be conducted in conditions of considerable secrecy (the various consultative and legislative bodies dealing only with limited aspects of Government). The press in Hong Kong is, perhaps surprisingly, free to comment. Furthermore, official Government pronouncements are more likely to emanate from press releases of the Government Information Service than from any public statements in the Legislative Council. Such press releases may coincide with specific events (the opening of a hospital for instance) or be in answer to instances of articulated public disquiet. Unofficial "leaking" of information to the press has also become more common.

The two Hong Kong English language dailies, the South China Morning Post and the Hong Kong Standard (and their Sunday variants) have been used in this study, in particular the former which was more accessible in the U.K.. There are certain difficulties in using media
sources. In an attempt to lessen the overt effects of editorial slant, newspapers have been used largely to quote Government or other spokespersons and to obtain information about the hospital service. Some of the information given has arisen out of investigative reporting and where this is the case, it is made clear in the context. In other cases the newspapers are quoting Government sources. In noting media sources, the possibility of inaccuracies must be acknowledged. In terms of overt political slant, neither paper can be clearly associated with a particular political stance although both are conscious of the time-honoured Hong Kong dictum of not "rocking the boat".

During field work periods, newspapers were studied directly. At other times, use has been made of the facilities at the Hong Kong Government Office in London, where comprehensive clipping and press release files are systematically maintained. Additionally, clippings files in the Kwun Tong Community Health Project were also used. Because of the use, in part, of clipping files, newspaper references are given simply with the date of the particular issue e.g. Hong Kong Standard, 23/3/86. The South China Morning Post is abbreviated as "SCMP".
4. **Other methods of seeking specific information essential to the arguments of the thesis**

a. **Data collection at United Christian Hospital**

As part of the assessment of the work of United Christian Hospital in relation to its avowed philosophy, specific sets of data were collected in order to demonstrate particular points. A fuller explanation of the rationale behind the collection of this data is given in the discussion in Chapter 4. The data collected was as follows:

- a 10% systematic sample of non-obstetric admission data at the United Christian Hospital;

- a systematic sample of employee address data for non-medical staff at the United Christian Hospital;

- a week long survey into referrals to specialist out-patients at United Christian Hospital;

- an examination of the addresses of volunteers working at United Christian Hospital.

b. **Formal approaches to Government agencies**

Formal approaches for specific information were made to the Medical and Health Department and the Fire Services Department (Ambulance Command) and this is acknowledged where used.
c. Interviews as a source of information

A number of persons, who were regarded as useful sources of information, were approached for interviews. The purpose of these encounters was largely to seek specific information or explanation and to obtain access to further sources and contacts. The choice of interviewees was determined by the information needed, the availability of the persons and the means of access to them. The persons approached included:

- a representative of the Eastern Island Hospital Coalition and the Chaiwan Community Health Project;

- a leading trade union facilitator and campaigner for social insurance (former Kwun Tong Community Health Project employee);

- an outspoken medical critic now in private practice;

- the senior consultant with W.D. Scott & Partners (consultancy review of hospitals);

- the Senior Administrator of the Kwun Tong Community Health Project;

- Members of staff at the Kwun Tong Community Health Project including GPs, nurse physician assistants, social workers;

- the Senior Nurse, Community Nursing Service, United Christian Hospital;
- a member of the Medical Development Advisory Committee;

- planning staff at United Christian and Nethersole Hospitals.

The above range of methods provided the information on which the discussion of the following chapters is based. The reader can now turn to the first chapter which deals with the development of hospital philosophies.
Chapter 1 The development of "hospital philosophies"

Chapter outline

The concept of a "hospital philosophy" - defined as a collective description of the beliefs, rationale and objectives that underly a hospital's functioning - has been proposed. This chapter argues that the development of such philosophies has to recognize complex cultural and social settings in the face of externally induced change and not simply be seen in terms of abstracted views of power relations. A framework is suggested that takes into account other factors.

In essence, hospital philosophies will reflect the tensions between philosophies of "health" and philosophies of "medicine", which themselves are the products of varied contributory factors. There seems to be a tendency for official outlooks to assume a "techo-medicine" (or "minimalist health") bent. The spatial consequences of such an emphasis are important. In recent decades, this emphasis has been challenged on a number of fronts, perhaps most seriously by the "Primary Health Care" movement instigated by the World Health Organization at Alma Ata in 1978. The implications of this for hospitals are discussed.

Primary Health Care itself is a development of preceding "Community Health" ideas. These have influenced one particular Hong Kong hospital whose published "philosophy" is examined in the light of possible contributory factors and its implications for the functioning of a hospital over space.
1.1 A framework for examining contributory factors

The fact that hospital "philosophies" are grounded, at least in part, in the realm of ideas and beliefs may be clouded by the attention paid in the literature to the organization of health care services being the result of dominant power relationships within a particular social setting. A number of approaches can be identified.

Very basically, Marxist approaches (e.g. Doyal, 1979 and O'Connor, 1973) see state provision of health care services in capitalist societies, as being primarily in the interests of the dominant class, out of a need to reduce costs of production and in response to proletarian demands in the class struggle.

In pluralist approaches, resources which contribute to power are seen to be scattered amongst a variety of groups (e.g. Willcocks, 1967). Thus, the provision of health care or the role of the hospital is influenced by the competing bids of pressure groups. Whilst different pressure groups vary in their ability to exert influence, no one group may necessarily dominate or be dominant consistently. Outcome arise out of some form of overall consensus.

In approaches which highlight sets of structural interests (for want of a better term - "structuralist"), different groups can be classed according to how they gain or lose
from the organization of health care services (e.g. Alford, 1975). The interests of professional monopolies, in particular those of medical doctors, may be argued to be dominant, challenged by the interests of the bureaucracy, with the losing group being the repressed consuming public. Pressure group struggles can occur but in this interpretation, the dominance of the professional monopolies remains.

In practice, all three approaches contribute to an explanation of the power distributions in the provision of health care services although each exhibits weaknesses. On a macro level, Marxist interpretations seem more convincing than at the level of specific policies or indeed at the level of what actually goes on in a hospital. Pluralist views may be argued to be superficial as they ignore deeper fundamental conflicts (such as the Marxist notion of class struggle).

If all three have some validity, it is tempting to examine where they may coincide in a less polemic interpretation. Ham (1985), for one, has concluded that this is not easy, arguing instead in favour of structuralist approaches which he claims

"encompass both the strengths of pluralist theory, recognizing the diversity and variety of pressure group behaviour, and some of the insights of the Marxist analysis, acknowledging that what appears to be going on may obscure underlying conflicts between key interests" (p 205).
Figure 1.1 shows interconnections in a most basic way. The existing political-economic system influences the state's perception of health care need as well as the bureaucratic mechanisms that enable the functioning of the state and its consequent provision of services. The existence of collectives of interest may be facilitated by the politico-economic system or the bureaucratic mechanisms to which the collectives have differential or equal access (depending on whether one subscribes to pluralist or structuralist outlooks). The same applies to the link between collectives and the role of the hospital.

1.2 Generalization and the unique

The danger of looking at relationships in this way, as with many models and social theorising, lies in their abstraction from "real-world" situations. This is brought home uncomfortably in Hong Kong where one is confronted, at least on the surface, with phenomena that seem quite extra-ordinary. It is not surprising that much comment on Hong Kong involves a celebration of the unique and it is not clear from Figure 1.1 what the factors that contribute to this uniqueness might be. For the commentator within Hong Kong, uniqueness has led to a tendency to dismiss established modes of explanation such as the above theoretical approaches (see Introduction). For the outside commentator, supposedly detached, this uniqueness could
Figure 1.1 A simple framework for examining contributory factors
possibly be more easily modelled into exemplars for a chosen approach. Since Hong Kong is commonly seen both as a great bastion of rampant modern capitalism and as a hang-over of 19th century laissez-faire (two quite contradictory notions especially when applied to state provision of health care), Marxist approaches stressing the dominance of the political economy may initially seem to be more appropriate (see, for example, McDermott, op. cit.).

In many commentaries, Hong Kong's uniqueness initiates in its extremely high density of population, its frenzied human activity in the absence of notable natural resources and the consequent juxtaposing of so many different people and things, almost literally cheek by jowl. This produces a colourful confusion represented well in the Hong Kong Tourist Association's invitation in advertisements to "discover the contradictions that are Hong Kong". Such variety weakens the case for such clear cut cause-effect analyses as might be tempted in a more traditional Marxist approach.

1.3 Generalization versus the unique in geography

This concern reflects a sentiment in geography well expressed in Gregory's observation that "our geographies will always be clinical autopsies if we continue to think
of places as examples of this model or that model, and only second (if at all) as settings in which people live" (1985, p.63). Post-war geography has tended to emphasise the general at the expense of the great variety that exists in what Johnston refers to as a "great mosaic of environments". He has stressed the need "to focus on the unique, to portray regional variability as local responses to general conditions, responses that create local environments within which future responses are set" (ibid p.115). In a point with particular implication for Hong Kong, Johnston comments that each region's response to capitalism or its version of it, is affected by the social, political and cultural settings in which the capitalist forces operate - "We are the creatures of capitalism, but not determined by it" (ibid, p.125).

This move back to a form of regional geography can be seen as part of a process over the past two decades to reincorporate human agency into geography, after what Gregory terms the "naturalism" emphasis dominated by rules and models, which looked at an object world like the natural sciences and was tempered only by the influences of behavioural psychology. The reactions to this have included a completely humanistic geography in which the existential significance of place as an integral part of human existence was explored, as well as phenomenological responses that focused on the ways in which humans
construct life-worlds that are meaningful to them. A third response that has grown out of these two responses, rejects both the reduced view of human agency of naturalism and the inflated view of unqualified humanism. This response - "structuration theory" - accepts human agency as important whilst recognising the effect of surrounding systems (ibid), not only reinforces the importance of a "local area study" type of approach, but also reflects the concerns already raised in the discussion of Figure 1.1.

1.4 Expanding the framework

There are additional difficulties with the simplistic picture of Figure 1.1. This frame of thinking can only accommodate change in a regulated way (as part of a class struggle or the competition between other forces). But change, as a perpetual feature of modernity, may be far more complex. What is certain is that change is a dominant feature and this is seen clearly in health services, not least in Hong Kong with its large increases in population and rapid demographic, and consequently epidemiological, transition.

Change affects the Hong Kong urban space in such a dramatic way resulting in what might be termed an "acute uniqueness", characteristic of places where the
change, that is endemic in all situations of modernity, is so obviously rapid and persistent. At any particular point in time the urban landscape must be regarded as unique — for it will surely change, sometimes beyond recognition, before long.

Another major omission, which also relates to notions of uniqueness, is that of recognizable collective notions of values and beliefs other than the crudest concepts of value attached to the accumulation of wealth, or the vested interests of particular groups. As mentioned in the Introduction, geographers have come to realise that unlike in the abstract world of models and theoretical structures, real-world systems do not function on featureless isotropic planes. Culturally, there are legacies of beliefs, values and interpretations which may vary over space. These are by no means static collections of cultural baggage passed on whole from generation to generation. They themselves change with re-assessment and new inputs over time. They permeate across the board, influencing (and being influenced by) the individuals, collectives in competition, and, without doubt, bureaucratic mechanisms of Figure 1.1.

Amongst these values, ideas and beliefs, two groups need to be singled out when looking at the essential question of "what a hospital is for" (a "hospital philosophy") — those of "medicine" and of "health". If, as increasingly
recognized, the latter is inevitably something with which an individual can identify on a personal basis, then some notion of the individual is another omission from the framework of Figure 1.1. The degree to which people can function with full independence, given their political, social and economic surroundings is open to debate. For the humanists, the individual, as a unitary, rational and non-contradicting entity, is the agent of all social productions and phenomena. For marxists and structuralists, the individual is a product of the structural relationships that govern the political, economic and social systems.

Post-structuralists have diverted attention away from the possession of power and the motivations of groups, classes or individuals in the exercise of domination to "the various complex processes through which subjects are constituted as effects of objectifying powers" (Smart, 1985 p.79). This approach sees power not as a commodity possessed by individuals but as something that circulates through the social body in a network of relationships in which all individuals are enmeshed. Individuals are not the agents of power, nor do they have their potential stunted by it. Rather, as Foucault (1973) has argued, through power, actions, intentions and ways of thinking come to be constituted as individuals. Whilst it is true that mechanisms of power have gained politicio-economic
utility, there can be no general theorising about how this occurs, for each situation must be assessed in its own right.

In arguing that power is closely associated with knowledge Foucault (ibid) has shown how this has developed in medicine. Alongside mechanisms of power have developed systems for assembling and accumulating knowledge which include methods of observation and research, and associated instruments of control a point that will be returned to below.

A final observation on individuality can be made at this stage. The linking of individuality solely to the exigencies of capitalism is a limiting view as it fails to account for vital human assets that can be displayed in health care - those innate and powerful human capacities for emotion, attachment, compassion and the selflessness of care in its finest form, all of which can transcend politico-economic systems. While it would be dangerous to claim that these superior human qualities prevail in any hospital, it would be equally dangerous to assume that they have no place.

An attempt has been made in Figure 1.2 to incorporate some of the omissions in Figure 1.1. The revised frame allows for cultural factors, for the flux of circumstances, for the role of some kind of "individuality" and shows that a
Figure 1.2  An expanded framework for examining contributory factors
hospital philosophy is at least partly influenced by the competition between the ideas and values of "medicine" and those of "health" and it is to this apparent tension that discussion now turns.

1.5 Medicine and Health

Crucial to the outlook of any hospital is the interpretation of the relative roles of "medicine" and "health". As Figure 1.2 has suggested, these are influenced by factors in addition to the simple dictates of a political economy and its facilitating bureaucracy. This discussion will emphasise how the understanding of these terms is linked to the beliefs and values of individuals and collectives.

"Health" and "medicine" are two problematic words. "Health" is arguably not even one of the "keywords" which (according to Williams, 1976) provide continuing dispute and ambiguity, and whose essential meaning can only be reached through discussion and debate. It is possible that there is no "essential meaning" nor, for that matter, any reason or desire for there to be. It is also evident that meanings change over time.
Meanings - definitions, theories, discourses

A pursuit of definition alone may inadequately reflect what people appreciate as the meaning or meanings of "health". Seedhouse (1986) has stressed the inter-relation of definition (fixed, specific labels, impersonal but communicable in language); theory (elements of reason, aiming for consistency internally and externally and therefore becoming independent of the theorist); concepts (personal outlooks based on feeling, memory and experience and which cannot be fully articulated); and conceiving (a capacity, not entirely language dependent that enables us to form theories and concepts and to choose, evaluate and decide).

The main health "theories" that Seedhouse identifies all have weaknesses. Talcott Parsons' theory that health is the physical and mental fitness to perform socialized daily tasks is too narrow an outlook and by being neutral (in that it sees health as a condition needed in order to continue as before), fails to see health positively as scope for improvement. Whilst the theory that health is a commodity, often associated with Marxist writers, has much to commend it in terms of modern practice, it relies too much on an assumption that scientific medicine is totally rational and that it is possible to cure purely through technical intervention largely outside the control of the patient. A group of theories associated with humanism,
which hold that health is a personal strength or ability that might have provided sound arguments against the commodity theory are, themselves, altogether too vague.

Seedhouse highlights the common ground— all these theories identify obstacles to the achievement of human potential and inspire responses that seek to remove, prevent or contain such obstacles. He sees health as being "foundations for achievement", and proposes a theory to encompass this. However, the need for a single theory, or indeed its possibility, can be questioned.

Seedhouse himself has pointed out that much literature confusingly refers variously to health as definition, theory or concept without distinguishing which is which and while for him, this appears to be a problem, it may be the coinciding of these components of expression that permits one to identify some general trends or movements in thinking which may be more helpful than specific academic theories. Actually, this interweaving of definition, theory, concepts and conceiving suggests what some commentators in health and other contexts have identified as "discourses"— systems of statements displaying a degree of unity.

Discourses are the systems of knowledge with which the power identified by Foucault (op. cit.) is associated.
Within such interlinked collections of statements, there is agreement on what can be said. At the same time, a discourse provides the means, through concepts, analogies or other mechanisms, for making new statements. Whilst having a unity and identity, discourses may also interlock with and overlap each other. Thus, if "medicine" and "health" are not interchangeable entities, it is still possible that within discourses of medicine and discourses of health there is some meeting. Discourses develop in response to "conditions of possibility", but in this they do not just emerge naturally - in fact, they are actively constructed. In the words of one geographer, they are not "free-floating constructions" but are "the painstaking and - often perilous - product of people in particular settings" (Gregory op cit p.57) which can be "deconstructed" in order to see their development.

1.6 Towards a broad contemporary understanding of medicine

Both Seedhouse and those advocating the idea of discourses, do suggest at least some points on which general consensus may be found. Some broad contemporarily agreed sense of what is actually meant by "medicine" can be established in the context of its relationship to "disease". The practice of medicine in the western world today, involves the analysis and identification (diagnosis) of identifiable disorders in the human body
and their subsequent treatment by some kind of intervention. Generally such disorders may be called "diseases". Disease arises when the human body malfunctions when compared with established norms. Each disease has its own aetiology, which may or may not be known to the science. Specific pathogens may be responsible. A full appreciation of aetiology and disease is conventionally facilitated by the deductive scientific method, which has developed from investigation based on careful observation, measurement and the pursuit of theory from hypothesis testing.

This has not always been the case. Indeed, the history of medicine has provided much material for the study of how ideas and discourses change. For Foucault (op. cit.) over a relatively short period of time, medicine has changed from the doctor's "gaze" at disease in a purely classificatory manner (distinguishing one disease from another without reference to the internal structure of the body) to a clinical medicine structured around the tangible space of the human form. From dealing with a medium of symptoms, medicine moved on to deal with a medium of tissues.

A conventional history of ideas (as indeed, the history that medicine has constructed of itself) would see this change as a logical and continuous progression of thinking. Foucault (op. cit.) has argued that by looking at
the ways in which groups of statements achieve some unity one can actually see discontinuities. The development of modern medicine is in reality an irregular and discontinuous change arising out of certain conditions of possibility. Ideas have to be linked with situations and influences current at the time of their development. In the case of medicine, conditions of possibility removed the incommensurability of clinical medicine and human anatomy. Furthermore, the actual object of medicine - the human subject as a physical anatomical form - is not an independently pre-given object about which doctors make discoveries, but itself the product of a particular discursive exercise.

In 18th century thought, death meant not only the end of life on earth, but also the end of the disease, its limit and its truth. With anatomical medicine, death (and its opportunities for dissection) offered a new vantage point, in the words of Foucault, a new "gaze". Whilst knowledge of the complexity of the system of the physical form has burgeoned, this gaze has made medicine a highly analytic process, dealing with specific diseases in isolation, instead of a synthetic approach to the body as an integrative whole -

"The emphasis on specific, individual etiology leads to emphasis on individual specific cures. Newer, multicausal theories of disease do not fundamentally question the basics of the disease approach which emphasises the disease rather than the patient, cure rather than prevention, and individuals rather than populations" (Illsley, cited in Allsop 1984, p.279).
1.7 "Disease" and "illness" and their relationship to "health"

It is helpful at this point to examine a distinction that can be made between "disease" and "illness" and the relationship of these to meanings of "health". Whilst to medical practitioners at least, disease is a technical state that they in a professional capacity can identify, "illness" generally relates to the experience of the individual patient. Thus, disease may be encountered without illness being experienced and vice versa. Whilst disease is viewed independently of the social environment, illness is culturally specific, dependent on folk definitions of normality which may or may not have a relationship to biomedical definitions. Illness has moral, psychological and social dimensions as well as physical, and therefore illness states or categories are as much a reflection of group definitions and responses as individual ones" (Allsop, op.cit., p. 145).

The fact that "health" is viewed as a corollary to both "disease" and "illness", is yet another reason for confusion in its meaning. In a purely disease-oriented, strictly medical approach, health symbolises the absence of disease - a state of "non-sickness" or technical normality. Such states may be relatively easy to identify but this has to be regarded as a "minimalist" view of health.

When looking at health as a corollary to "illness", deeper, less exact, meanings are glimpsed. The idea of
health as something more than simply non-sickness is not new. The United Nations' World Health Organization has, since its inception in the immediate post-war era, seen health as -

"a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity" (WHO, 1978).

This idealised state is unattainable by most, if not all, human beings and therefore such notions may be little more than well-meaning rhetoric. It is also very difficult to begin to define "well-being". In assessing the changing health-status of the Hong Kong population, Sun (1986) has proposed that it is more acceptable to think of health as a number of definitions along a continuum with utopia at one end, as suggested by the WHO definition, and something measurable at the other, accepting the highly subjective nature of "well-being" which makes it hard to measure quantitatively. In terms of Figure 1.2, the role of the individual as an interpreter of this needs consideration. Different people expect different things in life.

1.8 The role of broader religious and philosophical frameworks

People will, however, be influenced by broad religious and philosophical frameworks, which in Hong Kong include both Taoism and Christianity. Health does appear to be accommodated in the context of an overall cosmological ideology in the Chinese health care tradition. In this framework, health is seen as a state of harmony between
the body and the universe. The interdependent Yin and Yang have to be brought into balance if illness is to be avoided or ended. However, despite the conventions and established methodology, the actual achievement of that state becomes essentially a personal process. In the modern, increasingly individual-oriented world, there are many types of "balance", of "oneness" and of "harmony" with a rapidly changing and stressful universe.

Other traditions may find the state of well-being even more difficult to outline. At least, in the Chinese health care tradition, the search for balance, although dynamic in that it is constantly dealing with a changing situation and environment, is static in its objectives. The actual concept of the wholeness end-state is not questioned. It is attainable, at least for a short time. By concentrating on equilibrium, the philosophy is a conservative one in both literal and political senses.

The Christian tradition is more radical in the sense that, whilst accepting the need for a spiritual well-being, it places less importance on the personal short term balance and more on the ultimate goals of a long term improvement, of which health is a major component. The tradition stresses the importance of service to others (a basis to much western health care practice), and the perpetual conflict with a present and changing world, which itself must be both changed and transcended by the changes within
humans themselves. However, while the vision at the end may be clear, the road towards it is open to many interpretations.

Fundamental to this spiritual aspect as in the Chinese approach to health, is the concept that the body is not simply a sum of constituent functioning parts but a complex system of interdependency. To some extent, this can be rationalized in accordance with western scientific principles, although such notions of 'holism' can equally lead one to systems of logic, found in some isolated health cultures, that are inapplicable outside. Besides, as discussed already, notions of holism, internal balance and an interdependent well-being take on many forms. What is whole for one may not necessarily be complete for another.

Writing specifically for a Christian audience, Kingma suggests that "healing", which he defines as the process leading to the attainment of health, is not simply the result of technical intervention against disease. It arises through the joint efforts of several factors - the innate ability of the human body to heal itself (which may be variable and is certainly difficult to measure); simple non-medical measures; medical and surgical intervention and the essential mobilizing power of hope which must surely be a variable between individuals (Kingma, 1982). Of these factors, the modern hospital may provide just the technical intervention. Such an approach may seem alien to
a purely scientific, technological medicine, although many doctors will readily concede this, for instance in the differential responses of cancer patients with the same prognoses.

1.9 Identifying consensus - a problem for the state provider

Whether within academic spheres or the everyday world, it would appear that a single philosophy of "health" has been elusive. This is not to say that within groups and populations (collectives of interest and conscience in Figure 1.2), there may be something approaching a very broad consensus. What seems essential is that

"(h)ealth is situational, that is, it is related to what a people believes to be fullness of life for them. It is an expression of qualities to which they give value, and because they must choose between different factors in a world of limited resources, ethico-political decisions are involved. Health is evaluated by many criteria drawn from every corner of a people's life, including their capacity for enriching personal relationships." (Wilson, op.cit.,p.55).

Difficult questions arise as to how such a consensus on health is achieved in the modern world where the mass culture may be less influenced by religion and systems of cosmological order, where the roles played by the family or the spatial community are less clear and where an emphasis is placed on, or perhaps a mythology is fostered of, the importance of the individual. If the possibility of a degree of independence does exist, then within a mass
culture there could still be many responses to a fundamental concept such as health.

It is very difficult for government organizations, in the absence of an all-embracing doctrine or a recognizable public consensus, to cope with health in anything but minimalist terms. This is a least-cost option, at least in the short term, although technological medicine has a tendency to be associated with spiralling demand. Governments need objectives that can be easily justified and measurable outcomes that can be audited. Thus there is a tendency for an official "hospital philosophy" to reflect a minimalist health philosophy which itself mirrors a techno-medicine, purely disease-oriented outlook.

It is now more than twenty years since Christian Barnard captured imaginations the world over with the first heart transplant. In that time, disease-oriented, technological medicine has continued to develop, achieving great successes and consuming increasing resources whilst inducing increasing consumer demands. The rapid development of technological medicine has been in response to conditions of possibility arising out of technological expertise itself as well as the induced demands of the consumer. As has already been seen in excerpts from the Hong Kong media, the Hong Kong Government, as governments elsewhere, is under continual pressure to increase
spending on technological medicine.

1.10 The geographical implications of "minimalist health"

Such medicine is, by necessity, geographically concentrated in hospitals, for hospitals are "the epitome of the problem-solving, disease-oriented, applied science, engineering approach" (Kennedy, 1983 p31). As a former British Secretary of State for Health has pointed out, "(a)ll the romance, wonder and terror of modern medical science is associated with the hospital and its deep recesses: the hospital has prestige and inspires awe". But the lay public has an imperfect understanding of what is actually involved, not least because "for good measure, the hospital patient is often for one reason or another helpless" (Powell, 1976 p.34).

The pre-eminence of medicine has re-inforced the professional power bases within hospitals (that the structuralists have emphasised) or may have lent support to the Marxist view of hospital medicine as a form of commodity production and exchange demonstrating the commodified nature of health in capitalist society. In this "fetishism of commodities", people become objects while objects receive human attributes. Human relationships are turned into exchange relationships and those involved lose their human characteristics. This is how, it would be argued, hospital medicine reproduces
itself as a form of activity and as an institution and in turn helps to shape and support a capitalist social order (Eyles, 1982).

There has been a tendency in medical geography, when examining health care, to concentrate on technological medicine. As has been seen in the Introduction, for the geographer, the increasing facility-orientation of modern technological medicine has significance for the locations chosen or developed for such facilities. Indeed, much attention has been paid in medical geography to the movement of clients to facilities. The predominant emphasis, understandably, has been on the clients seeking out technical care as consumers. The hospital functions by drawing people in.

1.11 Challenges to a "minimalist health" view

Whilst this may be the most convenient outlook for Governments to adhere to, the predominance of disease-oriented medicine and its consequent hospital philosophy have not gone unchallenged. Views from a variety of standpoints, both from individuals and "collectives of conscience", question this as a sole basis for health care in the late twentieth century. In terms of the framework of Figure 1.2, such challenges may arise from "circumstances in flux".

Reflecting a general disillusionment with hospital
medicine, Wilson (op.cit.) for instance, has claimed that the modern hospital is based on assumptions that patients are individuals in isolation, with problems to each of which there is a solution; that the technical cure of the disease is paramount to the care of the patient; that "health" is considered to be something that can only be given to someone by experts who must assume power over patients; that death implies the failure of medicine and is the worse thing that can happen.

There are several groups of considerations that suggest inadequacies in a conventional hospital philosophy based on a technological medicine philosophy:

- the escalating sophistication and expense of technological medicine and modern hospital care and yet its apparent failure to deal with some of the major killers of today;
- the factors affecting individual responses - technological medicine is individual-oriented and yet through it the individual loses power over his/her circumstances;
- the glaring disparities in disease or disease-absence within countries and cities, and between countries, that persist and in some places grow.

These considerations have geographical implications. Geographers have continued to show interest in the association of environmental factors with cancer and other
"modern" diseases and have paid attention to disparities in disease-absence over a range of scales from local to international. As already mentioned, a preoccupation with utilization has involved examination of how individuals relate to facilities over space.

1.12 Technological Medicine and its weaknesses

There is a growing recognition that, despite the conquering of environmental diseases such as enteric diseases (at least in the developed world), many disease pathogens, often unidentified or unrecognized, may still originate externally to the body in the environment or the workplace and outside the control of hospital centred medicine. In addition, certain behavioural patterns not only appear to cause some diseases directly but may also predispose individuals to other ailments. It is significant that these types of diseases are often those that technological medicine is having the least success in tackling.

The rising cost of technological cures, if available, and the constant pressure to maximise returns on limited resources, has given extra credence to the notion that "prevention is better than cure" (e.g. Great Britain, 1976). It has been argued that since much health education lays stress on personal behaviour and lifestyle choices, it blames the victim and his/her moral failings for
disease, disregarding the overall effects of the social, political and economic domain (Navarro, 1976).

The pursuit of preventive medicine inevitably results in diverting investment away from the curative machine — the hospital — to front line preventive types of health care. Such a diversion might challenge the medical care philosophies on which the hospital philosophy is based. At present, these demands may meet with limited response partly because of entrenched interests within the hospital sector, to say nothing of public pressure for increased hospital spending. The public may be more impressed with the immediate visible intervention which the hospital offers than some distant and untried promise of a disease-free future. Additionally, preventive measures are notoriously difficult to evaluate over a short or medium time scale. Recently, studies have actually questioned whether prevention is cheaper than cure. Russell (1986), for instance, argues that prevention rarely reduces medical expenditure as it tends to produce better degrees of non-sickness but at additional overall cost. Furthermore, those living longer, will eventually require additional resources for geriatric and terminal care.

One feature of modern technological medicine is its concentration on acute service, which is where immediate technical intervention is required. Success in the acute sector, at least in preventing death, may in turn create
pressures on the chronic, long term sectors. The chronically sick may be able to live longer but in so doing, the locus of care becomes even more concentrated on institutions as opposed to the home. Costs therefore escalate, not only in acute care but also in the chronic sector.

1.13 Professions under attack

Whilst remaining a seemingly powerful and entrenched force, the medical profession, through its partial failure to deal with the most serious diseases of the industrialized world, has seen its stance weakened. Illich, from the early 1970s onwards, gave apparent credence to the view that the medical profession was actually responsible for doing harm. He argued that modern medicine damages patients (through iatrogenesis) on three levels - clinical iatrogenesis (wrong treatment); social iatrogenesis (the damage done to society where medicine intrudes into areas where other things could cope e.g. family); and structural iatrogenesis which follows on from clinical and social iatrogeneses and is a chronic state of dependence on the medical system reducing people to helplessness. To him, the medical professions have been responsible for the medicalization of life (Illich, 1976). Illich has since been attacked from many quarters. Horrobin (1977), defending the medical profession, has argued that there is a basic need for man to take heroic
actions, even if it does mean in Illich's eyes, 'hubris',
the procurement of the tools of the gods. 'Nemesis', the
consequent classical downfall for those committing hubris,
need not necessarily follow — adventure, on which so much
of the great achievement of modern medicine has depended,
may not always end in iatrogenic disaster and an equal
array of case studies can be produced to verify this.

Illich's structuralist view has also been taken to task by
Marxist commentators such as Navarro (1976), criticises
Illich on the grounds that the "professional imperialism"
on which he concentrates, is the product of the structures
and processes of a capitalist society which should be
instead the legitimate target of attack. Medical
bureaucracies and professional groups simply cater to the
need for consumption. Consumption is essential in a system
based on commodity production for profit. The dependency
demonstrated by the individual is not on medical god-like
experts, but on the commodity of health care.

Despite these criticisms, Illich has had impact. His
arguments for a deprofessionalization of health care and
greater personal responsibility by individuals for their
own health have proved appealing. The seventies and
eighties, in Britain at least, have seen a continuing
challenge to professional attitudes, generating a
significant degree of public interest as witnessed in the
response to the 1980 Reith Lectures by Kennedy, under the
title, "The Unmasking of Medicine" (Kennedy, 1983).

In Hong Kong, patients tend to "shop for doctors", switching frequently between practitioners during spates of illness and for different illnesses. This has been attributed in part to an allegedly arrogant and condescending manner shown by many doctors, especially when dealing with patients of lower socio-economic backgrounds, which leads to the patients' frequent dissatisfaction in their medical encounters (Koo, 1987), although as will be seen in Chapter 2, there appear to be many other considerations. In hospital medicine, the 1970s and 1980s in Hong Kong have seen increased public disquiet over professional standards and a great increase in litigation.

The public-versus-professional tension cannot simply be dismissed solely in terms of an attack on, and a defence of, unreasonable vested interests. From their positions within the system, medical professionals are often agents of change. Some commentators have suggested for example that the establishment of the U.K. National Health Service owes as much to professional pressures as to popular, socialist demands (Walters, 1980). In Hong Kong, there is much to suggest that doctors constitute the only pressure group able to achieve major progressive change within the system. Governments seeking change in health care systems may need to make great effort to woo professional
interests, a point that might have been initially neglected in the 1989 White Paper proposals in the U.K..

1.14 Factors that affect individual response

The professional-layperson tension reflects the growing importance of the modern individual. Despite, the ability of mass cultures to influence behaviour and attitudes, there is, integral to modern society, a belief in individual choice and freedom. Whilst some of this alleged freedom may be part of a society's mythology, depending on personal circumstances, there will be varying degrees of ability to act and to believe according to one's own desires and conscience. These freedoms may not have grown or may even have declined, but their status as ideals is nevertheless maintained.

In modern capitalism, individual decision making is inextricably linked with the rise in material consumerism, of which health care seeking can be an important part. On the surface, this would seem to reinforce technological medicine which is geared to providing intense technical attention to individuals, treated in isolation to their social circumstances. For many, this isolation is precisely what they demand.

Mass consumerism has encouraged a widespread awareness of
"quality", however this may be assessed. Consumerism encourages notions of "rights" and these are essentially interpreted with reference to the individual, spawning a nominal belief in equal, if not equitable, access and availability. Increasing levels of education and a lessening of the distinction between professional and non-professional for some groups, have led to more questioning of technological medical practice. This may be exacerbated by both the difficulties that inevitably arise with a situation of finite resources that will exist in any health care system, and the problems that arise when technological medicine confronts its limits of competence, as may be the case with some of the major diseases today.

Beyond the level of external behaviour, as the discussion on "health" above has suggested, the role of the individual remains a vitally important consideration. Accepting the belief that there might be, for want of a better word, a spiritual aspect to health in the sense of something which meets deep, internal, non-physical needs presents problems for a solely technology based medical outlook as much as it does to a Marxist view of health as a commodity.

1.15 Disparities and Inequalities

Technological medicine is inevitably concentrated in specific locations at the points of service delivery. These may have little bearing on the spatial disparities
in disease and disease-absence that are found. In practical terms, of all the challenges, it is the recognition of inequalities that has received the most systematic attention in the past decade.

In the United Kingdom, pronounced regional variations in resource inputs to expensive hospital care received considerable attention with the Resource Allocation Working Party, whose recommendations have since been partially effected. These did not challenge the basic concept of technological medicine. A different perspective of spatial variation was assumed by the Working Group on Inequalities in Health, whose Black Report in 1980 not only highlighted the inferior morbidity and mortality of those in the "lower" socio-economic groups but that their relative position had deteriorated since the inception of the National Health Service (Townsend and Davidson, 1982).

On a world scale, periodic catastrophes have served to remind that the severest discrepancies exist between Developed and Developing Countries, between underdeveloped rural and developing urban worlds and within the rapidly growing urban centres themselves. Within developing countries such capital intensive hospitals built at the expense of basic health care on a wider and more equal scale, have come under increasing criticism.
Responses to these challenges

These challenges to a minimalist health view have had profound implications for hospital philosophies. As far as Hong Kong is concerned, much of the debate has occurred outside the Territory. In terms of Figure 1.2, the extent to which these debates will influence the Hong Kong hospital philosophy may depend on the extent to which Hong Kong institutions and collectives of conscience and interest are susceptible to external influence.

In both developed and underdeveloped worlds, there have been responses to these challenges from government and non-government organizations. In the United Kingdom, areal disparities in hospital inputs, once identified, provoked attempted adjustments to the spatial allocation of resources. This did not however, lead to any noticeable change in the role of hospitals, or the hospital philosophy. However, larger scale international disparities have led to rethinking of the role of technological medicine. In developing countries at least, questions are increasingly asked about the number, type and function of hospitals to be built.

The new mood is best portrayed in the ideas of "Primary Health Care" brought together and given considerable legitimacy at the International Conference on Primary Health Care at Alma Ata in 1978. This conference,
organized by the World Health Organization and UNICEF, recognized that -

"The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries." (WHO, 1978 op.cit. clause 1)

The conference ended with the now famous ten point Declaration setting out the ways in which "Health For All" - qualified as "a level of health that will permit them to lead a socially and economically productive life" (from clause 5, ibid) - might be achieved worldwide by the year 2000.

The Declaration defined "Primary Health Care" (PHC) as -

"the essential health care based on the practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and family can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (ibid, from clause 6).

The details of PHC are reproduced at Appendix A. These provided an impetus in the move away from concentration on the hospital as a centre or even a source of "health". Instead the first level of contact, near to peoples' lives and work, becomes the level of prime attention.
Origins of Primary Health Care in the "Community Health" movement

The ideas of Alma Ata were influenced by what could loosely be called a "community health movement" which had gained considerable ground across the world since the 1960s. This had particular relevance to rural parts of the developing world where resources were scarce and where the most glaring diseases were environmentally or nutritionally related and seemed relatively straightforward to tackle and where the need for hospitals to be aware of circumstances of the populations they served seemed greatest.

Proponents of "community health" stressed that responsibility for health had to be assumed by people themselves, that people working together in their natural communities could contribute resources that were otherwise lacking, and that great improvements in health were attainable so long as people had a basic understanding of their own communal environments. Several collections of case studies, largely of rural community health projects, served to capture the imagination of many, although the enthusiastic rhetoric may have clouded critical analysis of real achievements (Newell, 1975; Rifkin, 1977; Morley et al, 1983).

One weakness of the movement is that there seems to be no single definition of "community health". It is not just
"public health" or "environmental health". Neither is it, in the generally accepted understanding of the term, "community medicine" which can be defined as the study of "the distribution and natural history of disease in populations so that societies can devise and plan preventive programmes and services for the sick" (Farmer and Miller, 1977).

Rifkin states that "nearly everyone agrees that community health means participation of the community in the health care programmes" (Rifkin, 1977, op.cit. p.10) but how exactly this participation is viewed, varies greatly. Some would hold simply that "organized community effort is the key to community health" (Anderson et al, 1978). Rifkin herself, critically distinguishes those projects where the community are not only participating but are actually involved in decision-making.

The possibility of public participation in health care other than as simply consumers, has been discussed since the 1950s and its origins can be traced to the "community development movement" which had its heyday in India and West Africa in the 1950s and early 1960s. Participation gained further exposure in Latin America in the 1960s and 1970s in movements that specifically recognized the importance of socio-economic inequalities (de Kadt, 1983). In practice, as de Kadt has noted, participation in
decision-making has been much less widespread or genuine than participation in the implementation of health related activities. This he attributes to class structure and like Rifkin, to the entrenched interests of medical professionals.

The Alma Ata Declaration, while not defining community health, did deal with related concerns and so gave disparate organizations a common and recognized cause. Whilst not going as far as some community health proponents, by pronouncing that

"The people have the right and duty to participate individually and collectively in the planning and implementation of their health care " (clause 4, WHO, 1978 op.cit.).

the Declaration gave a certain legitimacy to community health initiatives, which in some places had been regarded with political suspicion. Indeed, since Alma Ata, many Governments have made changes to overall policy, influenced by the ideas of primary health care.

1.18  The implications of Alma Ata for hospitals

This philosophy has a wide application in underdeveloped and rural parts of the world where there is an urgent need for resources to be diverted from the urban centres of excellence to the low level technological efforts of the rural health worker and community volunteer. It has been,
however, harder to see its relevance in more developed and urban areas. It has been argued that the failure of the United Kingdom’s National Health Service to pay anything other than lip service to Alma Ata is partly the result of misinterpretation of its aims (Green, 1987). Some provision for hospitals was made in the Declaration, but it was not well understood. Calls for "appropriate technology", for instance, have been interpreted as calls for low technology or seen with suspicion as cost cutting. In the UK, other than the distant national democratic process, which is virtually irrelevant in the PHC context, the public has no democratic influence on decision-making. The Community Health Councils act more as consumer watch dogs.

The rhetoric of the Declaration gave some licence to a burgeoning anti-hospital ethos especially as it coincided with the anti-professionalism of Illich. Rifkin, for instance, had no doubt that one of the prime causes of the "health crisis" throughout the world was "the predominance of the doctor as the sole conveyor of health care leading to the paralysis of the individual to act to improve his own health" reflecting the views of many at that time (Rifkin, 1977 op.cit., p. 9). There has been a subsequent tendency to make extravagant claims. Morley has stated categorically that over the past thirty years, "the international community has come to understand that hospitals, large and small, do not provide the sort of
health care which most people need" (in Morley et al, 1983, foreword). Ten years on from Alma Ata, this ethos has aroused certain misgivings. In the light of experience, the hospital is seen to have a role to play and steps have been taken by WHO to explain that role (WHO, 1987).

1.19 Hospitals and "Health For All"

In 1987, WHO published a booklet "Hospitals and Health for All" in which it sought to clarify the hospital's role and in effect to establish a hospital philosophy (WHO, 1987, op. cit.). A model (Figure 1.3) is used to identify the functions of facilities at each referral level in a comprehensive health system, of which community health is but one aspect. Comprehensive health care is viewed as a dynamic system with flows of people, information, goods, services and opinions both into and out of each level. By looking at the primary health care elements and the functional infrastructure as the two component axes of a matrix, the need to consider the interrelated nature of the whole system and the need for intersectoral collaboration (with fields outside medical care e.g. sanitation) at each level is emphasised.

The WHO report emphasises the significance of the social and political context of the community the hospital serves.
Figure 1.3 A conceptual model of a comprehensive health system based on the principles of primary health care

(after WHO, 1987, p. 21)
so that the "inward and outward flows are thus moulded by such forces as population density, economic development, the attitude of the medical profession, and the degree of decentralization and integration of the political system". It argues for "community involvement/intersectoral collaboration" at all levels (ibid).

This model can be criticised for certain omissions such as the vital element of rehabilitation in the primary health care programme and the restriction of environmental elements to just "water and sanitation". Additionally, at least when presented in its diagrammatic form, the model gives the impression of sequential links only, whereas there is a need for links to be made up and down the tiers regardless of the level. The model makes no attempt to suggest how such a comprehensive health care system might operate in space.

However, the intersectoral collaboration that is the key to the model provides the basis of a hospital philosophy that extends far beyond the confines of technological medicine. It is interesting that many aspects of this idea have been fundamental to the philosophy of a hospital-led community health initiative in Hong Kong that predated Alma Ata. It is appropriate at this stage of the discussion to look at this particular initiative as a means for understanding some of the implications for a hospital's relationships with the space of the city.
The United Christian Hospital is an acute-general hospital in Kwun Tong in eastern Kowloon, an industrial area with a population of 700,000. The philosophy of the hospital's controlling body, the United Christian Medical Service, is reflected in the goals quoted in Table 1.1. These represent the only example of a published hospital philosophy in Hong Kong and capture something of the enthusiastic way such ideas were expressed in the 1970s. Taken literally, these goals impart massive intentions, yet are impossible to quantify or evaluate. They embody frequent recourse to terms, such as "health" and "justice", which seem all-embracing, meaningful and appealing, but which evade precise definition.

A literal analysis, however, may do these tenets a disservice in that these goals, are really the intended building blocks of an encompassing ethos. A resultant new health care culture may pervade sufficiently to determine priorities within the strictures of the overall health system and might affect the interaction between the service organization and its service space. In essence, it would seem that this ethos comprises the following elements:

- a recognition of a broad basis to health, that mechanical curing is not the only concern, that
Table 1.1 The goals of the United Christian Medical Service
(as stated in the Annual Report 1986-7 (UCMS, 1977))

(All quoted)

UCMS is dedicated to serving the community in its quest for Health which is not only the absence of disease, but means the physical, mental and social well being of individuals and the Community.

It serves the Community by helping sick people to find health in their home, in health centres and in hospital.

It serves the Community by giving people the knowledge how to keep health and prevent sickness.

It serves the Community by enabling and encouraging people to play their right role in creating Health which means accepting responsibility for their own and their neighbour's health, showing concern for the needs of deprived people, setting right their relationships and guiding the Community towards Justice.

UCMS is a learning, teaching, communicating, responsible and open service, working as an integrated whole towards the hope of a true Community, living as God intends it to live.
health, whatever it is, is something that is created and does not just happen;

- a recognition of the need for people themselves to be involved, to some degree, in their health care, for them to have obligations and responsibilities, for them to have concern too for the health care of others;

- an emphasis on service as a manifestation of giving, indeed even a suggestion that giving is essential to health;

- an emphasis on openness, on access, which enables learning and communication by all — providers, recipients and participants in the health creating process;

- a recognition of an ideal or ideals to work towards which involve radical improvements to life and living as opposed to simply technical improvements to non-sickness status.

These elements are rooted in a non-evangelical socially aware Christian tradition but one which does not specifically identify major structural changes in society as an essential prerequisite for change in the health of community although it is interesting that some of the early advocates in UCMS were also looking very favourably at Maoist inspired health care methods in China (China
Health Care Study Group, 1974). Underlying all seems to be a belief that people have the ability to transcend structures in order to live together effectively as communities. Effective community living, whatever this may be, is seen to be an essential component to health. The proponents of these ideas were greatly influenced by contacts in similar organizations outside Hong Kong.

Such an outlook has potential for determining the hospital's relationship with its surrounding space. As will be shown in Chapter 4, this hospital has been the only one in Hong Kong to consider the importance of location in this way and to pronounce a specific role for a well-defined service area. The philosophy suggests the possibility of a "centrifugal" relationship, in which the emphasis is less centred on the hospital, but rather on looking out to the service area in an investigation and anticipation of needs, prevention of hospital visits and a preference for dealing with health care needs in the community and the home. This contrasts with the "centripetal" outlook that seems to prevail in the conventional hospital philosophy, in which the hospital waits for patients to present and sucks in the resources from the service area. On the basis of this, the United Christian Medical Service has attracted non-Government resources into the community-targetted health project with a network of health centres. In addition, a far greater
openness has encouraged participation in volunteer activities and various outreach programmes in its service area. These will be critically assessed in Chapter 4 below.

1.21 The concept of the service area

As has been suggested, for the United Christian Hospital, identification of and with a circumscribed service area has been an important consideration. Service areas are a representation of the ways in which hospitals relate to the space of the city and the people they serve. It is argued here that the nature of relationships with the service area is affected by the particular hospital philosophy. Some simple models are used to demonstrate this.

The service area of a hospital can be defined as the geographical area for which the services of the hospital are intended. This may vary in size depending on the nature of the services provided, especially in terms of specialization. Size also depends on levels of provision elsewhere in the hospital system. For specialist hospitals, the service area may be a large regional or even national scale. For acute-general facilities, the service areas are more likely to be regional or smaller scales. Hospitals can aim to provide self-sufficiency in service for their service areas or they can act
interdependently with other hospitals. Again, this will be related to the kind of service offered.

The nature of what goes on in a service area varies greatly. Service areas can be located on a continuum of types between two extremes which can be labelled:

- purely catchment or

- fully interactive service areas.

These two extremes are distinguished in Figures 1.4.1 and 1.4.2. In the purely catchment type, the hospital receives patients from the area either through referral or from self-presenting. The hospital makes no attempt to communicate with its service area. Patients are simply discharged after treatment. The hospital accepts no responsibility for anything that goes on within the area outside its walls, is engaged in no preventive work or health promotion activity.

At the other extreme in the fully interactive service area, the hospital is one element in a highly integrated health care system with excellent communication between all levels, transfers of information and resources to maximise effectiveness throughout (full intersectoral collaboration). Patients are referred up and down the levels and there is a genuine transfer of resources and assistance from the hospital to its service area, for which the hospital has a high level of responsibility.
Figure 1.4.1 Catchment and interactive service areas with impermeable boundaries

Figure 1.4.2 Catchment and interactive service areas with permeable boundaries
Figure 1.4.1 shows impermeable boundaries to the service areas. In practice, service areas can be areas—

- from which patients are allowed to come or
- from which patients are expected to come.

In most situations, there will be a degree of "import" and "export" across boundaries of varying permeability, whether officially sanctioned or not. This is shown in Figure 1.4.2.

A defined service area is administratively convenient as it provides a basis for:

- a central authority (such as the Government) apportioning responsibility for hospital care delivery. If the service area corresponds to a geographical political unit, authority can be devolved to that unit;

- the effective distribution of resources;

- defining areas of monopoly;

- co-ordinating activities and resources within a spatially inter-linked system;

- evaluating a hospital's performance in comparison with other hospitals (WHO, 1987 op.cit., p. 28).

For these reasons, most hospital systems will have some division of service areas, however nominal they may become in practice.
Service areas that tend towards the interactive extreme, such as those in "community health type hospitals":

- give an areal basis to data collection that is essential to monitoring the wellness of an area, assessing its needs, and monitoring its environment (although boundaries may have little relevance to some environmental problems);

- may give the flexibility needed to adjust hospital services to cater for the special needs identified (described as being "extraordinarily difficult" (ibid, p. 28));

- may be able to engender within the service area some feeling of identity with the hospital, increasing confidence in it, support for it and co-operation with it;

The interactive service area may be regarded by proponents of community health as being coincident with a spatially defined "community". This is based on a number of assumptions:

- people grouped together in residential location can function as an effective community and may have their own decision-making mechanisms;

- if this is not the case, then they can be helped to function together effectively as a community;
people so functioning as spatially defined communities provide the best arena for the development of -

i) personal responsibility for health;
ii) responsibility for care for others;
iii) education and change in behaviour;
iv) participation in health activities.

There are some additional attractions -

- an identifiable space may have identifiable problems;
- strong spatial communities may be more able to work to improve their environmental predicament;
- well functioning spatial communities provide some kind of security net that "catches" those missing out. In communities where the members are not anonymous, it is easier to "target" individuals and groups "at risk" and in need of special attention or help.

1.22 The spatial community - a critical view

There are, however, serious conceptual and practical problems arising out of the notion of "community" in a rapidly modernizing urban world. "Community" has become "an untidy, confusing and difficult term", its multiple facets include "a cliche and a rallying cry; an analytic
"Community" has been the concern of academic sociology throughout its history and an inheritance from its past still affects modern approaches. The discipline's founding fathers, including Comte and Durkheim, used "community" as a varying means of "invidious comparison with contemporarily exemplified society", the latter being characterised by the upheavals of industrialization and the anonymous urbanization of the 19th century, with its competition, conflict and contractual relations (Bell & Newby, 1971, p22). Community, as envisaged, was the antithesis to all this.

It is a "pervading posture of nostalgia" that has influenced many peoples' approach to community ever since. Ferdinand Tonnes (from 1887) developed the theory through his concepts of Gemeinschaft (with its dominant aspects of blood, place and mind resulting in kinship, neighbourhood and friendship - warm, caring, small and identifiable and associated with the rural village) and Gesellschaft (the large scale, impersonal, rational, utilitarian domain found in the industrial city where man was alienated and mechanical). This dichotomy may have been founded more in myth than in reality. Much of 19th century country life
was extremely harsh; to many, communities presented a
tyrranny that was opposite to the freedoms promised by an
industrial age. In the mass rural-urban migrations into
Hong Kong over the past 40 years, people have moved to the
call of the city – its offer of some hope, some freedom as
well as its more material attractions. Few return to the
stultifying lifestyle of their former village, at least
within their working lifetimes. Despite these
inconsistencies, the supposedly positive aspects of the
rural life have remained a popular ideal. The idea of
coop-erative living is popular with Christian health care
workers in the developing world for whom the alienation
caused by the urbanization of peasantry seems readily
apparent.

For the purposes of a geographical analysis of service
areas, it is important to assess how the notion of
community relates to space. Clearly, the traditional rural
community as envisaged, was a "community of place" where
location and belonging to that location were important.
But in the modern city, where neighbours may lead
completely unrelated lives and where a high degree of
mobility extends an individual's spatial interaction, the
spatial community is much harder to identify and to
sustain.
Considerations of service area and community definition apart, the location and interaction of a hospital subscribing to a community health philosophy must take regard of other factors. One important influence lies in what constitutes communal involvement and to what extent communities are given roles in decision-making. To some commentators this is the most important factor in health care delivery.

Rifkin, whose conclusions are derived from a study of three community health programmes including the United Christian Medical Service in Hong Kong, sees the role of community participation in community health as a major criterion for evaluation of community health projects (Rifkin, 1985) She argues that health care planners approach community health from three bases:

- the medical approach which holds that good health can only be obtained through a highly developed western medical service and that all health related problems should be dealt with by medical professionals;

- the health planning approach (best demonstrated in the Primary Health Care movement) which works for an appropriate delivery of service that ensures coverage for those with the greatest need and the fewest resources, while accepting that medical advance is only
one aspect in an integrated system of health improvement;

- the community development approach which believes that community health improvements do not have to start with medical advances, that improvements in non-medical fields or changes to the social structure may be priorities and which thus relies on a "decision making process which focuses on community wants rather than policy makers' needs" (ibid, p. 13).

Rifkin implies, in her explanations, her own disapproval of the medical approach and, although aware of some of its problematic nature, a general sympathy for the community development approach. She does not question the appropriateness of the community development approach to the different levels of societal organization that are found in rural, underdeveloped urban and well-developed urban situations.

Rifkin argues that planners reveal a particular approach when they confront six issues vital to programme planning which are shown in an outline of her model in Table 1.2. This matrix summarises likely responses to these six issues by adherents to the three basic approaches. She cautions that not everyone identifying with a particular approach may see all issues in the way suggested and that the way community involvement develops over time will
Table 1.2  A classification of Community Health
(after Rifkin, 1985, p.36)

<table>
<thead>
<tr>
<th>ISSUES/ HEALTH SERVICES</th>
<th>PARTICIPATION</th>
<th>ROLE OF PROFESSIONAL</th>
<th>ROLE OF COMMUNITY HEALTH WORKER</th>
<th>EVALUATION</th>
<th>FINANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL</td>
<td>major programme component for providing better service key</td>
<td>service extender</td>
<td>health status statistics</td>
<td>from whatever source available</td>
<td></td>
</tr>
<tr>
<td>HEALTH PLANNING</td>
<td>necessary but not sufficient for maximizing resources component</td>
<td>service extender/ change agent</td>
<td>efficiency / effectiveness</td>
<td>from outside working towards self-reliance</td>
<td></td>
</tr>
<tr>
<td>COMMUNITY DEVELOPMENT</td>
<td>a means for community mobilization for creating improved social structures resource</td>
<td>change agent</td>
<td>education process</td>
<td>self-reliance is primary goal</td>
<td></td>
</tr>
</tbody>
</table>

- 112 -
depend on which approach dominates the project at a particular point in its evolution.

However, if Rifkin's classification of responses into approaches is to have meaning, then a certain cohesion within an approach must be assumed. These different approaches represent differing community health care philosophies in which hospitals could be involved. The different approaches could affect a hospital's spatial relationships with the community.

Spatial aspects were not considered by Rifkin, but the liberty is taken here to interpret how these approaches might affect the relationship of facilities, such as hospitals, to the space of the community. Using Rifkin's characteristics as a starting point, each approach has been translated into a diagrammatic representation of a community health system involving a hospital and a community health programme (Figures 1.5.1, 1.5.2 and 1.5.3). For each, interpretation is offered of the locational and distributional implications of the components and links. In Chapter 4, the community health project of the United Christian Hospital will be tested against these models.

In the Medical Approach (Figure 1.5.1), medical professionals, whose power base is the hospital, are seen as the major enactors and recipients of resources for
Figure 1.5.1 The medical approach to community health

- Hospital location regarded as of prime importance in terms of service provision.
- Links over space to raise logistical concerns.
- Location of outpost geared to maximise service impact.
- Location of "at risk" groups could be of importance. Population density is a consideration.

Diagram:

- HOSPITAL
  - Resources
  - Referrals
  - Emphasis of initial community health resource allocation

- OUTPOST
  - Community as consumers
  - Feedback
  - Extension of service by health professionals
Figure 1.5.2 The health planning approach to community health

- Extenders of service & agents of change
- Additional resources
- Hospitals
  - Location of environmental factors as "at risk" groups
  - Links over space and logistics
  - Maximise use of resources and effectiveness
  - Raises logistical concerns
- Health Authority
  - Resources
  - Referrals
- Community
  - Unmapped resource base
  - Environmental problems
  - "Problems"
Figure 1.5.3
The community development approach to community health

[Diagram showing the community development approach with labels for Health centre, Hospital location, Logistical concerns, and the process of community development leading to effective units and change.]
Community Health. They determine standards and activities in their outreach programme comprising medical services. The community is seen largely as a passive recipient of services, but making a contribution in terms of feedback. Feedback enables adjustments to service activities where necessary. Geographically, it can be concluded that because of the prime importance of the hospital, its location within the area may be a major concern. Since medical intervention is the key to health care in this approach, locations that maximise the effect of medical service should take priority.

In the Health Planning Approach (Figure 1.5.2), the more encompassing basis to health activities, involving not only medical intervention but also factors causing ill health, could lead to different locational emphases. In this approach, resources are made available for medical intervention, environmental change and behavioural change. It can be suggested, therefore, that location serves not to maximise service impact but to maximise use of resources (although the two may coincide). Since the front line unit, by being a co-ordinator of activities, is more than simply a provider of services, its location may have to be one which maximises this role. The appreciation that the community experiences not only varying needs, but also varying environmental and social problems, as well as an appreciation of its nature as an untapped resource itself, should be a major determinant in the distribution of
health activities, as well as for facility location.

Finally, in the Community Development Approach (Figure 1.5.3), the emphasis is on the existence of effective community units which have developed, or which can be developed, to an extent whereby they can alter the structures and conditions that condemn their members to ill-health, and can assume directly, the responsibility for their own health needs. It can be argued that for such communities, the location of facilities (of whatever level) is initially important from a point of view of convenience only. The facility exists as a resource for their use, rather than a determinant of their health status. However, it might be logical to deduce that ultimately, such communities may determine a facility's activities and thus may determine its location.

1.24 Conclusion

The case of the United Christian Hospital shows how important ideas and beliefs are in formulating a stated philosophy. These ideas have been developed by individuals and groups - the collectives of conscience and interest of the framework of Figure 1.2 - working within a particular tradition of health care and making choices on the basis of particular beliefs. These beliefs affect the interpretation of the "medicine-health tension" leading to
an emphasis away from a "minimalist health" stance. These ideas have also been stimulated by outside contacts with sympathetic organizations and movements abroad. As Chapter 4 shows, such contacts have also been instrumental in financing some of the initiatives of United Christian Hospital. The outside influences are one aspect of the "circumstances in flux" (Figure 1.2) that give impetus to new ideas and developments.

Written statements of policy are one thing - how these are actually implemented is another thing altogether. The framework of Figure 1.2 shows factors which can, in effect, be constraints. To what extent "independent" ideas can exist in the overall system is the subject of succeeding chapters, in particular Chapter 4 when the operations of United Christian Hospital are examined in detail. Before this can be done, it is necessary to try and ascertain aspects of a prevailing "philosophy" for the system as a whole.
Chapter 2

Aspects of the prevailing Hong Kong hospital philosophy

Chapter summary

In Chapter 1, a framework for examining factors contributing to the development of hospital philosophies was suggested. While it is possible for ideas to develop within this framework, the extent to which ideas can have practical application depends on the nature and strength of prevailing attitudes and the constraints that some of the factors in the framework present.

Using the framework, factors that have contributed to the prevailing hospital philosophy are examined. Whilst the political economy is clearly very important in the exigencies it imposes on the bureaucracy, it is vital that analysis is not abstracted from the rich cultural environment of Hong Kong, nor from the "circumstances in flux", many of which are directly related to events and circumstances external to Hong Kong and completely outside the bureaucracy's control.

The chapter starts by examining the politico-economic system and the functions of the bureaucracy. Circumstances in flux and external influences are then dealt with followed by an assessment of the importance of the cultural context. Through this can be seen how the bureaucracy functions not only to maintain capitalism but also to deal with unique problems at the interface between western and Chinese cultures. This has had a direct bearing on the development of health care services, both in the present and in the past, as an historical account of the development of health services shows. A legacy of government attitudes to activities at this interface plus an acceptance of conventions of health care behaviour go some way to explaining Government attitudes to Primary Health Care and the functions of hospitals.

In the absence of written declarations, any view of prevailing philosphy will inevitably be somewhat speculative, leaning heavily on circumstantial or anecdotal evidence and interpretations of statements and actions. However, by looking at some key aspects (such as those that United Christian Hospital has apparently concentrated on), an idea of prevailing attitudes can be gleaned. Such attitudes are discussed throughout Chapter 2 and are brought together in the concluding section.
2.1 The importance of the politico-economic environment

In Chapter 1, Figure 1.2, whilst recognizing other factors acknowledges the importance of the politico-economic system in influencing prevailing hospital philosophies. Hong Kong appears to be unashamedly devoted to the accumulation of capital. The capitalist mode of production distributes through a powerful series of self-sustaining mechanisms that pervade many aspects of life. In this pursuit of wealth, there is little overt regard to distributional justice, although the Hong Kong Government increasingly finds itself under pressure to pay lip service to this. Whilst the Governor in 1950 could happily go on record as saying "We are just simple traders who want to get on well with our daily round and common task", a more recent Financial Secretary has felt the need to stress that -

"the whole purpose of our policy of the encouragement of the creation of wealth is not to enable the rich to get richer but rather to achieve an improving standard of living in all its respects for the whole community" (HK Govt, 1983, p.4).

One sympathetic analyst of the Hong Kong financial system, has claimed that budget speeches in the 1960s "show greater concern for the mass of Hong Kong residents than for the immediate financial interest of the middle class" (Rabushka, 1976). No direct mechanism to facilitate redistribution is ever suggested and certainly not progressive taxation. Rather, the Government has argued
that redistribution comes automatically through spin-off from continued growth. In general terms living standards and employment opportunities have indeed improved. However, Hong Kong remains a very unequal society.

In the liberal Hong Kong market, rapid gains and growth are possible. Controls are limited, profits can be high and taxation remains low. Governor Youde, in his 1982 inaugural address, asserted that the Government policy continued to aim -

"to leave the industrial, commercial and financial sectors free and unfettered to compete in domestic and world markets, regulating only where the orderly conduct of business, fair treatment of the workforce and the good name of Hong Kong so require" (HK Govt, 1983, op.cit., p.4)

However, the Hong Kong Government, increasingly frustrated by its lack of monetary instruments, has moved in recent years towards greater regulation and financial accountability. This has come in the wake of scandals that have affected that "good name of Hong Kong". It is doubtful that the Hong Kong market of the 1980s can justify the commonly ascribed comparison to that of laissez-faire 19th century Britain.

It is true, as has been seen, that the Government remains an adamant defender of free trade. It is true that much of Hong Kong's production still takes place in small industrial units averaging only 18.5 workers, reflecting
the network of subcontracting and the petty capitalism of the family business. However, at the same time, monopoly capitalism, significant in Hong Kong since the 19th century in the form of the great trading houses (the "hongs" of the Jardine Matheson ilk), is also important.

Today, despite some 19th century hang-overs, Hong Kong is inescapably part of an international trading system and displays many of the aspects of advanced capitalism, despite the apparent lack of state involvement. Many Hong Kong firms now assume a multi-national perspective. Conditions increasingly favour an oligopolistic market place and the Government increasingly is a major consumer, although not of armaments or aerospace items as might be the case elsewhere. The Government consumes largely in support of the infrastructure including health care. It is such spending, more than any other factor, that makes the situation today so unlike that of the 19th Century.

The increase in Government consumption in fields like health care might enable Hong Kong to be labelled a "welfare state". This term is not actually used to describe Hong Kong, either by the establishment, for whom such a term would arouse the deepest suspicion, or by liberal critics, ever quick to demonstrate the paucity of social provision. However, if one is to use a definition such as that of Gough -
"the use of state power to modify the reproduction of labour power and to maintain the non-working population in capitalist societies" (1979, p.45).

then Hong Kong complies. The Government's view is summarised in this statement from the 1964 Medical Development plan -

"a good general standard of health throughout a community is an economic asset to it and helps to condition the levels of energy and initiative which determine productivity, particularly in a free enterprise economy...." (H.K. Govt, 1964 - emphasis added).

But what does a general standard of health entail?

The Hong Kong Government provides a wide and increasing range of services that ameliorate conditions for the people. Apart from housing over 40% of the population and providing homes for sale for thousands, free and compulsory education for 9 years is provided in addition to health care services. There is a system of non-contributory, strictly means-tested public assistance benefits, parsimonious though they may be.

These provisions do benefit, indirectly, capital accumulation processes just as similar provisions in China, of a much sparser variety, have been essential to the operation of the socialist economy. In Hong Kong, these further serve to alleviate difficulties caused by the distorted distribution of the capitalist system, providing the basic safety net to prevent the complete
collapse of certain sectors of society. But services have gone beyond the basic levels.

Until the mid-1970s, there was little evidence of investments in welfare in Hong Kong being made in response to specific public pressure. An apparent contradiction that the welfare state controls the proleteriat and yet is the result of proleterian pressure has been demonstrated by Gough and, in the case of the UK health service, by Navarro (1978) although Walters (1980) has countered that much of the change in the UK health system came as a result of professional pressure and Green (1985) has asserted that this actually destroyed working people's own efforts in the health care field. In Hong Kong, political life until the 1980s has been characterised by public disinterest. Pressure, if any, has come from specific pressure groups, which may have included professional interests. Government response has generally been slow and evasive.

In practice, a poor and unimaginative record of the Hong Kong Government in the primary health field, other than in vaccination, mass screening and contraception (examples of cheap technological intervention of a techno-medical philosophical approach) may indicate that the Government has not fully filled the role suggested by Gough. In contrast, provision of secondary levels of health care in Hong Kong has strayed beyond the point of the basic
'garage maintenance' of the working class (although care is still very much dominated by a medical model). New developments have to be seen in the light of responses to a more demanding and affluent society which may even talk in terms of provisions being 'rights'. These new developments cause the greatest expense and pose the hardest questions when it comes to the allocation of restricted resources, for how does one define what should or should not be provided?

2.2 "Social expenses" and a propensity to crisis?

This dilemma is, of course, not unique to Hong Kong. O'Connor (1973) has examined in detail the nature of state consumption in advanced capitalist systems in order to explain the tendency of such systems to move towards crises. He identifies two major categories of state spending — "social capital" and "social expenses". Social capital comprises two forms of spending — "social investment" (investments needed to improve productivity) and "social consumption" (investments needed to reduce labour costs). Both forms of spending are needed to aid the capital accumulation process. "Social expenses", on the other hand, are not required to aid capital accumulation, but simply to maintain social harmony.

According to O'Connor, increases in social investment and
consumption lead to increased private investment and consumption. This could result in surplus capital which creates surplus population, by substituting capital for labour and creating the unemployed and underemployed. These, in turn, necessitate increased social expenses. The crises, in O'Connor's thesis, occur through the recurrent conflict between an ever-increasing demand for service that can only be provided by the state and the willingness of the public to foot the bill. Such demands and their consequent implications for legitimation of the state and its activities begin to threaten the whole capital accumulation process.

Despite a low unemployment rate, spending by the Hong Kong Government in all of O'Connor's categories has increased dramatically over the years, although in terms of percentage of GDP, it may appear small in comparison to the industrialized west. Social investment in the post-war period has involved large scale land reclamation and water supply projects (both of which, interestingly, have their origins in the 19th century). The 1970s have seen investment in transport, in new towns and industrial estates. Social consumption is seen especially in the housing programme. Recent decades have also seen significant social expenses in leisure, the arts and conservation of the countryside so much so that some 40% of the territory is now protected as "country parks".
Aspects of health care spending in Hong Kong now fall into both the categories of social capital and social expenses. It could be argued that the trend in Hong Kong is towards the state-induced crises that O'Connor talks about. In health, demands for improvement now arise out of heightened expectations, the so-called diseases of affluence, ageing of the population (those unproductive people beyond the working age and never to be productive again) and improved levels of education. Such health care investments arguably fall into the "social expenses" category of O'Connor — that bottomless pit which is especially problematic in Hong Kong where the public is unaccustomed to high taxation and many to taxation in virtually any form at all.

Fees at Government and subvented hospitals, if charged, are extremely low and almost insignificant in terms of running costs. Government spending is limited by a small taxation net that collects income tax from only about 9% of the workforce, with 6% of the workforce paying over half the receipts. There is no system of contributory national insurance. The financial restraints imposed clearly influence the kind of health care system that has developed in Hong Kong. The political institutions have functioned to execute very tight financial policies over which the highest levels of Government retain strict control.
There is competition for resources from education, housing and transport. Whilst the Government, through its own hospitals and those run on Government subventions, provides 88% of Hong Kong's hospital beds, its spending on health care amounts to only 8% of total expenditure. This amounts to little more than 1% of GDP and estimated by some to be only 25% of the total spent on health care in Hong Kong (Hong Kong Observers, 1983).

2.3 The basic financial constraints

Hong Kong has been financially autonomous from the UK Government since 1958, an autonomy which can be seen as a "reward" for the Government's successful financial policy (Endacott, 1973). Rabushka (op. cit) attributes the "brilliant performance" of successive Financial Secretaries to a Governmental structure where by chance and other factors, their role has been unrestrained, amounting to that of "a virtual autonomous dictator". According to Rabushka, throughout the 1960s and 1970s, the "budgetary tail wagged the policy dog", although the Financial Secretary does not formulate non-financial policy. He simply sets the scene in which policy can be made and in so doing constrains the options. The power of the Financial Secretary already well established, has been further strengthened by the agreement with China that spending will be kept under strict control up to 1997.
Just because the people of Hong Kong do not vote for their Government does not mean that its standing is not affected by its performance. In Hong Kong this is often judged by the fact that the budget is balanced in both policy and in practice. Large financial reserves are maintained, enough in the 1970s, for instance, to finance over 6 months' spending. Public Debt is generally avoided and Government Departments are characterised by extreme austerity with habitual underspending. In the past, the Hong Kong Government has tried to seek popular approval through its high standards of housekeeping. Whilst this remains important, especially to the business community, there are widespread demands for a comprehensive hospital service which such tight spending controls make very difficult to run. Serious problems have arisen because the Government has attempted to provide such a service without the necessary resources. This is not to say that by simply increasing resources, problems that exist would be eradicated.

2.4 An outline of the bureaucracy

It is necessary to examine the "bureacratic mechanisms" (Figure 1.2) in more detail. The section of the Civil Service responsible for health care matters is the Medical and Health Department (henceforth MHD). It is led by the Director of Medical and Health Services who answers, in
theory at any rate, to the Secretary of Health and Social Services, who in turn answers to the Chief Secretary.

The Chief Secretary is an ex-officio member of the Government's Executive Council (Exco) which comprises the four key senior bureaucratic officials and a majority of nominated non-Government members selected from the highest elites. This is presided over by the Governor and constitutes the main policy directing body. The link between MHD and the centre of policy direction is therefore indirect.

Neither the Director of Medical and Health Services nor the Secretary for Health and Social Services are ex-officio members of the Legislative Council (Legco) although they may be nominated to sit as official members. This body has a legislative and finance-approving role but not really a policy-making function. Government officials do not sit on the Urban Council (Urbco) which through its control of the Urban Services Department has responsibility for a wide range of sanitation and public health related measures. There is no formal MHD involvement on the District Boards, whose scope is far more local and whose function is largely advisory. Some District Boards have links with subvented hospitals, but there is no formal involvement of District Boards in hospital management.
Of this hierarchy of bodies, the District Boards and Urbco are partially elected. From September 1985, part of Legco has been elected on the basis of functional constituencies covering major professional groups, commercial bodies and trade unions. Further democratisation of Hong Kong's institutions has been hotly debated, both before and after Tienanmen 1989, and any further moves will be strongly contested by Beijing.

The lack of formal representation on the legislative and executive bodies does not mean that the medical profession is without a political voice in Hong Kong. Doctors have, in the past, been successful candidates in both District Board and Urban Council elections. From September 1985, the medical profession gained one seat on Legco as a functional constituency (nurses were not included in the original functional constituencies but in 1988 gained a seat).

There have always been doctors on Legco, either by chance or tradition, and at times as many as three Legco members have been practitioners. In addition, from the 19th Century when a doctor became the first Chinese on Legco, the doctors represented have predominantly been Chinese. The extent to which these medical Legco members represent their profession obviously varies. Some have tended to be more outspoken than other Legco members, although even at its most vocal times, Legco has not in the past been much
other than a rubber stamp. The revised Legco has already proved itself to be much more vocal as the functional members exploit the increased media interest, criticising policy, not that Legco is the place where policy is formulated.

2.5 Spending control within the Medical and Health Department

The Medical and Health Department demonstrates very strict policies of spending control. Cable (1985), who has favourably compared the MHD's financial management systems to those of his own Health Authority on the Isle of Wight, cites in particular, the Department's Performance Review Committee which has a disciplinary role as well. Before this committee, personnel responsible for "financial inadequacy, indiscipline or mismanagement" can be summoned. Cable refers to the financial system being "superbly documented" with tight control exercised by a hierarchy of accounting teams, staff of which are seconded from the Treasury, an important political point which Cable misses. It is a scenario in which nobody will dare make any mistake and therefore will surely avoid making any decision that in any way is out of the ordinary. The Department has invested heavily in computer based financial analysis but the apparent sophistication of computer modelling and advanced accounting methodology should not obscure the fact that there is an obsession
with 'spending control' as opposed to more innovative forms of 'cost control'. This obsession extends down through the system to hospitals and clinics.

The Hong Kong Observers (op.cit) refer to the "flabby administration of the MHD" but this is not a criticism that outside commentators, such as Cable, would make. Even within Hong Kong, one persistent critic of the health service, has conceded that "the MHD has done a pretty good job when it comes to spending its money as best as it can" (Ding cited in Anderson, 1984). Indeed, there can be little room for flabbiness. The MHD attempts to run what, given the circumstances, is an ambitious level of provision.

The pre-occupation with expense stringency nurtures and in turn is nurtured by a highly authoritative departmental structure with few decisions being dealt with at low levels. This results in an overload of decision-making in the upper ranks who often deal with quite trivial matters. Regionalization of health care services after 1974 (see Chapter 3) failed to fully decentralize the Department with the regional offices referring matters "back to HQ" even in relatively minor concerns. Delays in decision-making from the top, which are inevitable, make the whole system incapable of dealing with rapid change. While decisions are referred upwards, information may be
kept at lower levels and so decisions, when they are made, are made in a certain degree of ignorance. Any decision-making or bureaucratic activity at lower levels is bound by what Lau (op. cit.) perhaps simplistically regards as a fetishism for rules, the perfect refuge for the Hong Kong civil servant.

In all matters, MHD approaches the world in a regulated and, some would say, a regimented manner. One might even suggest that an element of the old colonial military style of operation persists from the days of public health drives. After all, doctors are still referred to as "medical officers" and in government service, at junior levels, are transferred from institution to institution and from specialty to specialty without having any say in the matter - one of the doctors' complaints. This is the same kind of regime that will actually contemplate disciplinary proceedings against staff for over-spending targets (Cable, op. cit.). In fairness, similar military connotations are still found in Britain (see e.g. BMA News Review 21/12/85). The notions of "attacking disease" reinforce the interventionist stance of technological medicine reducing the victim to a helpless state.

Whilst the bureaucracy must essentially be viewed as part of the politico-economic system, its character and identity is not solely moulded by that system. One problem
with commentators such as O'Connor (op. cit.) is that they work at a high level of abstraction. In their approach there are several assumptions. Firstly, the assumption that things such as class, or perhaps spending, can be sensibly categorised into water-tight compartments. As life becomes more complex, this becomes increasingly unrealistic. Second is an assumption that just because activities and investments happen to support the operations of capital accumulation, they are necessarily designed to do so. The notion of some grand co-ordinated and rational scheme, like Marx and Engels' "committee for managing the common affairs of the whole bourgeoisie", is too simplistic for any society where there is a vast diversity of interests within capitalist groups, a range of levels or scales on which they operate, in a world of complex relations and varied cultural values. Third is the assumption that people, at all levels in society, operate consistently in materially rational ways. This is a cynical assumption that denies human capacities. The very identification by O'Connor of "social expenses", apparently needed to maintain harmony in an unjust world, is an indication that the basic needs and aspirations of human beings transcend the mere material. If health is conceived in terms of a totality, possibly involving even spiritual dimensions, then it not helpful to try and analyse the provision and the utilization of health services in a purely materialist way.
In Chapter 1, factors not necessarily considered in such abstracted approaches were also suggested. The Hong Kong bureaucracy can be affected by external influences as discussed later in this chapter. For instance, the Hong Kong civil service has been greatly influenced by western management methods and practices. In an attempt to solve its hospital crisis, the Government has employed an Australian-based consultancy firm.

In a later section to this chapter the theory that the bureaucracy has striven to keep apart from the Chinese society will be examined. Even if this is the case, the bureaucracy's employees cannot escape their own culture. Whilst still under British leadership, the civil service is manned predominantly by Chinese. Cultural considerations of "face", of order and status are evident and respected. In the case of the MHD, the bureaucracy is additionally deeply affected by the culture of the medical professions, particularly of the doctors (as "collectives of interest") who make up nearly all the most senior ranks.

The MHD is exceptional in the sense that its senior bureaucrats are not generalists as is the case in much of the rest of the civil service. Following a belief that it is only doctors who understand health care and who can control other doctors, the high level bureaucrats are invariably senior hospital medical personnel or hospital
administrators promoted, some might say, sometimes beyond their level of technical competence, having reached the end of their promotion prospects within the hospital service itself. This has contributed to the dominance of the technological medicine, minimalist health philosophy which seems to influence much of the health care policy and result in a failure to grasp essential issues in primary care.

This dominance of the medical profession has led to the senior posts being occupied by Chinese, still an unusual state of affairs in Hong Kong. Since the 1960s, the Directors have all been Chinese, although not necessarily Hong Kong Chinese or Cantonese-speaking. This does not seem to have improved the Department's ability to communicate with the Chinese society at large. The MHD is widely regarded as the most isolationist of all Government departments and the poorest at communicating with the public. The MHD is a professional department involving a profession that in the Hong Kong context is highly elitist and closed to scrutiny. Allegations of an 'old boy network' appear in the press (HK Standard, 21/11/76). A degree of mutual support and defence is offered providing there is no breaking of ranks or public discussion (Hong Kong Observers, op.cit.).
2.6 Public participation in the bureaucratic process

The ways in which people as individuals or collectives of conscience and belief outside the professions can influence the bureaucracy in health care matters are very indirect. There is an absence of direct public consultation or efficient public access to information. Complex informal networks of influence do exist but these are hard to quantify. Such networks exist within the subvention system (see below). Of the professional groups, those associated with the two Universities and their medical schools may have greater influence. Certainly within the two university linked hospitals, different funding arrangements allow a greater clinical and operational freedom. This has created a very distinct two tier system amongst the major hospitals. Away from the university hospitals there is no provision for research and very little provision for professional development and training. Junior medical posts are not regarded as training posts as they are, for instance in the UK.

There is some nominal public involvement in special Advisory Committees - quangos which were set up largely under the Maclehose Governorship in the 1970s. One is the Medical Development Advisory Committee (henceforth MDAC). The public members of this are, however, predominantly medical professionals suggesting a formal route for "collectives of interest" (Figure 1.2) to influence the
bureaucracy. However, it cannot necessarily be said that they are the agreed representatives of their professional groups although most recently, the Chair has been the medical functional constituency member of Legco. How important the MDAC is in reality, is open to doubt. In recent years, its Chairs have chosen to use other vehicles, such as Legco, for expression of views.

2.7 The Medical Development Advisory Committee

The MDAC was set up in 1973 and its role outlined in the Government's Green Paper on medical developments for the next decade. In the 1980s, the Terms of Reference were:

"to keep under continuous review the state of development of the medical and health services; and to advise the Government, through the Secretary for Health and Welfare, on the further development of Medical and Health Services, having regard to all factors which affect the progress of such development" (MDAC membership documentation).

Proceedings are officially clothed in secrecy, although in recent years a considerable amount of information has been leaked to the press. In January 1985, the Secretary for Health & Welfare wrote to the MDAC reminding it of the need to explain its terms of reference to the public and requesting more frequent releases of information to the press. At the next meeting this letter was given cursory attention with the membership proposing that at the beginning of each meeting it would be decided what could
and what could not be disclosed to the press. Minutes of subsequent meetings suggest that this practice was not followed although certain members of the MDAC continued to make their own contacts with the media (MDAC minutes 1985).

The MDAC meets only 6 times a year. The agenda is not set by the Chair. Technically, it is set by the Secretary for Health and Welfare, but for all intents and purposes the agenda is an internal matter of the MHD. In the 1985-6 session, the Chair invited members to submit their own papers but there is no evidence that this happened (MDAC minutes, 1985 and 1986).

Papers are prepared by research staff at MHD, presented to members and then discussed. When plans concern service provision, the following procedure pertains:

- a planning ratio per thousand population is devised, often without any real explanation as to the rationale for that ratio;

- requirements are then calculated on the basis of this ratio for various times in the future;

- provision is then calculated based on the facilities planned in the Medical Development Programme but without taking into account the priorities within this
programme. (The Medical Development Programme is the most deceptive of all MHD's documents. The mere listing of a facility on the programme is virtually meaningless. What is crucial is its real status in the Government's capital works programme);

- shortfalls, if any, are then calculated.

It is difficult to see the point of discussion in such a scenario. Examination of MDAC minutes reveals little dissension. Not surprisingly perhaps, the air of a "gentlemanly club" (and the membership is predominantly male) prevails. It is felt by some members that membership is more important as a means for gaining information, informally and formally, than for any involvement in planning or policy making. There may be occasions when opinions expressed at meetings are relayed back to policy or decision-makers. Whatever, the MHD continues to claim that decisions are "made by the MDAC" although it is interesting to note that in the 1986-7 Annual report of the Medical and Health Services (HK Govt.,1987a), the Director made no mention of the committee. But then, neither does he make mention of the overlord Secretary for Health and Welfare, re-inforcing the commonly expressed belief that in reality, he is answerable to the Financial Secretariat alone.
The range of topics discussed by the MDAC is given at Appendix B. Very few of these items can really be considered to amount to major policy directions. Rather, they take the form of ad hoc responses to problems or issues. Sometimes this may be in response to external pressures. A comparison between items on the annual agenda and items actually discussed for the session 1986-7 is included in the table showing how things can be changed over the year. This was partly in response to outside pressures but even so, the overall impression given is of quite chaotic bureaucratic thinking.

In general, items discussed reflect a heavy concentration on manpower concerns (14 papers - often dealt with in an extremely crude way - anything more imaginative such as postgraduate training is left to other groups set up for that purpose); a recurrent concern with hospital beds (5 papers); and hospital facilities (7 papers). Discussion of individual infirmaries seemed to predate any real discussion of the new Government Infirmary Policy. Virtually no consideration is given to the role of Primary Health Care. Primary facilities were discussed only once in four years.
2.8 Circumstances in flux

Figure 1.2 emphasised the importance of "circumstances in flux". These circumstances will have bearing on other factors as well as being influenced in turn by them as the link between circumstances external to Hong Kong and those internal to it is often close. Hong Kong exists at the mercy of China, to whom it will revert in 1997 and of the United Kingdom who as its colonial master, determines at least its foreign relations.

Change is a common characteristic of the late twentieth century and arguably a fundamental condition of modernity, both in 'physical' terms of urban and economic institutions and also in the social fabric and the nature of the individual and his/her relations. In Hong Kong, change has involved Hong Kong's rapid transition from a sleepy entrepot of the pre-Pacific War years to its position today as the world's 17th largest industrial exporter, one of the most important financial centres and in 1987, the second busiest container port in the world. Hong Kong is now popularly classified as one of the four "dragons" of the Asia-Pacific region - economies that have rapidly grown in recent years through industrialization (Chen, 1988). Its per capita income of US$ 8292 in 1987 was on a par with that of New Zealand. Even after taking into account the great inequalities in income that prevail, the average Hong Kong citizen enjoys a material
standard of living that is high by Asian norms. Despite its industrial base (which in any case is declining in importance due to a shift in production to subsidiaries and joint ventures within China) Hong Kong remains largely dependent on trade and thus highly susceptible to swings in the world economy and to protectionist measures in the EC and USA. Down turns in the world economy have, in the past, led to Government spending cuts which have adversely affected health care investments.

Urbanization and industrialization have had major impact on social relations and traditional cultural institutions including the family. Values and beliefs, from which health and medical philosophies draw sustenance, are challenged by changing circumstances, are found wanting and may be redefined. In addition, Hong Kong has also been influenced by the importation of ideas and practices from the modern world outside. Transference of ideas is not always straightforward as is shown by the response of Hong Kong mothers to current western "fashions" in breastfeeding namely rejection with less than 10% of mothers maintaining breastfeeding beyond a month after birth (Li et al, op.cit).

The importation of ideas has been instrumental in maintaining the status and in setting standards of medical and paramedical professional groups. Both basic medical and post-graduate medical training has had to be approved
by the appropriate bodies of the United Kingdom. Indeed without this, it is likely that standards within hospitals would have declined appreciatively. The Royal Colleges of the UK have increasingly expressed their reluctance to continue to act as approving bodies. In response to this, and also in recognition of changing needs with the approach of 1997, the Government has moved to establish a Hong Kong Academy of Medicine (H.K.Govt., 1987g). The working party for the establishment of this Academy was chaired by a UK Professor contracted for the purpose, showing a continuation of external influence and particularly British academic and professional interests, although it was interesting to note the failure to appoint a local person was hotly debated in Legco (SCMP, 8/8/85).

2.9 Unremitting population change

The very high population growth due to mass in-migrations from China is shown in the data in Figure 2.1. It is this rapid growth that has put the most immediate strain on hospital services and has contributed to the MHD's obsession with adding beds to the hospital system. It would seem that in doing so, MHD has ignored changes in population structure that have resulted from declines in crude birth and death rates (Figure 2.2). These are shown by the age-sex pyramids in Figure 2.3.
Figure 2.1  Hong Kong population growth, 1951-1987
Figure 2.2 Crude birth/death rates, infant and neonatal mortality rates, 1956-1986
Figure 2.3  The changing age-sex structure of Hong Kong 1961-1981
Changes have also occurred in the distribution of population within the Territory. The increases in population have led to great pressure on a very small land area and the consequent opening up of other areas as well as the construction of new land through reclamation (see Chapter 3 for details). Future trends can be projected. Whilst population projections in Hong Kong have to be made in the knowledge that substantial in-migration and emigration can upset figures, they do give some indication of the types of change at work. Twenty-year projections see the average age of 29 years in 1986 increasing to 40 years by the year 2006 when only 16% of the population is expected to be under 15 years of age (23% in 1986). The proportion of those aged 65 and over (8% in 1986) is projected to increase to 13% by 2006 (HK Govt, 1987d). This increase in the number of elderly presents major challenges for already inadequate social services and hospital facilities. Changes in family attitudes have contributed to an estimated 2500 hospital beds occupied by elderly people "deserted by their families" (SCMP, 3/12/86).

2.10 Change in an "epidemiological transition"

A number of health status indices show improvements over the years as in the impressive declines in Infant Mortality and associated measures (Figure 2.2). The
general ageing of the population and the steady improvements in living standards have been reflected in an "epidemiological transition" (Phillips, 1986).

Generally, the communicable diseases that were prevalent in the 19th and the first half of the 20th centuries have declined or have been virtually eliminated. The main causes of death today are malignant neoplasms, heart diseases and cerebro-vascular diseases giving a death profile very similar to that of a highly developed western country. A Hong Kong citizen, at birth, can expect on average to live to 79 years if female, and to 74 years if male. New demands for medical care are presented by these changes in epidemiology and population distribution requiring a hospital system with flexibility and a capacity for anticipation and change.

2.11 Change in the shadow of 1997

No study of Hong Kong can today ignore the overall political changes that are taking place in the handing over of rule from Britain to China. As Hong Kong moves towards a future after 1997 and the formal ending of British Rule, the importance of external forces is clear and in many ways, events are outside the control of Hong Kong people of any status. There has always been an element of uncertainty pervading Hong Kong stemming out of
what the author Han Suyin called a "borrowed place" in "borrowed time". Outlooks have always been short-term. The oft-quoted common wisdom is that investments must fully recoup within five years.

By the terms of the agreement ratified by London and Beijing in May 1985, Hong Kong will become a Special Administrative Region of China (S.A.R.) on July 1st 1997. The conventional principle of self-determination adopted by the United Kingdom with regard to all other colonial possessions in the post-War era has been set aside. Not only has the future been committed to Hong Kong by powers quite external and in many ways divorced from it, but a timetable, to which strict adherence is needed, has also been imposed. In a media poll conducted in 1987, some 48% responded that they wished "Hong Kong to stay part of Britain" while only 16% opted for Hong Kong becoming a S.A.R. of the Peoples' Republic (SCMP, 15/12/87). Despite the apparent freedom shown in huge public demonstrations against the current Beijing regime in May and June 1989, political activity in Hong Kong remains constrained by the wishes of Beijing.

The new S.A.R. of "Xiang Gang" is supposed to have a certain measure of autonomy, the exact nature of which will depend on the current development and application of a proposed "Basic Law". China has promised to maintain the "present system" for another 50 years. It could be argued
that if the fundamentals of the Hong Kong capitalist system are left unchanged, as is the stated intention, the bureaucratic and organizational change that will follow will only be superficial to the basic forces of resource allocation.

Nevertheless, the changeover from a form of British Colonialism to what some might regard as a form of 'Chinese Colonialism', will inevitably require some administrative change. There will be new roles for the Hong Kong citizen. The extent of this will depend on how far more representative forms of Government develop within Hong Kong, a process that perpetually runs into opposition from China. The increased localization of the civil service, today hampered by large-scale emigration, should also have an effect. So will a general move away from British influence in education and cultural matters. It is possible that systems of patronage will alter.

The recognition in Government of the need for change is shown by one statement by the Director of Medical and Health Services. Talking of the "winds of change which are now upon us ... blowing ever stronger", he argued that "(r)adical changes, political, social, economical and administrative (sic)" presented the need for the health service to "adjust itself" to the changes (HK Govt., 1987a, p. 4). However, no suggestions for self-adjustment have,
as yet, been suggested.

In a sense, many of the changes that can be expected in the run up period to 1997, might have been necessitated in any case by the changes in the structure and nature of Hong Kong society, the international trading system and expectations of world political opinion. The 1997 question thus serves to focus issues that would have arisen in due course.

2.12 A rich cultural heritage

As has been argued in Chapter 1, an over-concentration on the political economy may obscure some of the other factors influencing the way hospitals have functioned in Hong Kong. Whilst the bureaucracy on the surface appears to function solely to maintain the working of the political economy by responding automatically to its demands, in reality, relationships are more complex and intriguing. It is helpful to explore these in greater depth at this stage as they have a close connection with the way in which health services have developed and the way in which the subvention system has evolved. An historical approach is needed.
The cession of Hong Kong to Britain in 1841 was a direct product of 19th Century capitalist trading expansion. As a spoil from the First Opium War, Hong Kong was regarded as a great disappointment, but this was largely immaterial as Hong Kong's value was not to be assessed by what could be earned from it itself - it had no raw materials and no market - but by how it could facilitate the trade between China and Britain. Its importance was in its service function for capital accumulation that was quite external to it. As a Colony, throughout the 19th century, it was a financial disaster. In the early days, the priority of the Colonial Government was the maintenance of stability in a potential fire place of cultural conflict.

It is this concern with stability that has led to Lau Siu-kai's attempt to place socio-cultural factors at the helm of explanation instead of the political-economy (Lau, op.cit.). Fundamental to Lau's work is the co-existence of contrasting cultures that dates back to Hong Kong's earliest days as a Colony. His thesis centres on an analysis of the political stability of Hong Kong despite the existence of highly destabilizing conditions and an "anachronistic polity". He argues that this stability is achieved through a "minimally integrated state" with "utilitarian familism" (relations built on complex networks of extended families) as the dominant feature of social organization.
Lau maintains that Hong Kong retains its remarkable stability in the face of rapid modernization and an apparently anachronistic government style through basic processes of depoliticization. To him, these processes are not fundamentally part of the capitalist accumulation process, but have arisen spontaneously both from the polity and Chinese society. The population has been remarkably apolitical despite a level of individual freedom that by Asian standards is very high. Apparently, this is because what has evolved in Hong Kong is a "minimally integrated social-political system" in which there is a distinct separateness between the bureaucracy and the Chinese society with the bureaucracy in a dominant position, its dominance resulting from its own limitation of function. According to Lau's thesis, the Chinese society, although extremely diverse is generally made up of extensive networks of familial groups within which exchanges and sharing of resources are strong. Such groupings may help to lessen the significance of class in Hong Kong.

The bureaucracy and the Chinese society are "boundary conscious" and strive to maintain their separateness. Boundary changes will tend to be gradual and small. While politics takes place at the boundary, it remains
peripheral to most people's lives. Gough (op. cit.) and others have also highlighted the necessity for a distinction between the political and economic spheres in western capitalist societies, but would argue that this is needed, not for socio-cultural reasons, but for purely economic ones i.e. successful capital accumulation. In the case of Hong Kong, socio-political necessities have created the environment for capital accumulation.

Such a system can be maintained providing two conditions are met. Firstly, society is resourceful enough to cope with problems that emerge. Secondly, the bureaucracy does not intrude unnecessarily to restructure society, but instead maintains depoliticization and identifies and solves problems which society cannot cope with itself. Lau adds that the maintenance of this political stability is a continuous process which is always surrounded by a degree of uncertainty and maladjustment. Conflicts do arise from time to time especially if they are instigated from outside the system, such as the 1967 riots which were a spin-off from the Cultural Revolution in China (Lau, op. cit.).

Whilst it is possible to challenge Lau on some of his statements, his analysis remains interesting from two points. One is the attempt to view the Hong Kong situation in a cultural context modified by a larger political context (ie British rule in China in a post-colonial age).
In addition, Lau suggests a societal structure which permits capitalism to flourish strongly and no doubt gains strength from capital accumulation in return, but in no sense can be regarded as an automatic product of capitalism.

Lau's own evidence is quite weak in the pre-Pacific War era and the 19th century when, much of this framework must have been set up. There is clearly scope to expand these ideas especially in the field of medical and health care to which they seem to be highly relevant. Lau also pays inadequate attention to the forces of change that are present within a modernizing, and to some extent westernizing, society. The familial unit on which so much of his interpretation depends, will likely be modified in time. If expectations continue to rise, the bureaucracy may be called on to intervene more in the Chinese society. Indeed, the Government is increasingly intervening and in this respect, the demands for improved health care are very important. Any new form of Government in the pre-1997 or post-1997 arena will find itself under severe scrutiny and may be forced, whatever its ideology, to be seen to intervene.

Lau first published his work before the Joint Declaration on Hong Kong's future. Since that agreement, there has been much talk in Hong Kong about increasing democratic
participation—in other words politicization. To an outsider, such talk might have seemed timid until the mass demonstrations of June 1989 that featured up to one million people supporting the Tienanmen students. Beijing had expressed its concern over political activity long before these anti-Beijing demonstrations. A feeling that has been expressed in both Hong Kong (amongst business leaders) and in Beijing, is that democracy would in fact weaken the autonomy that has been cultivated by the bureaucracy in a minimally integrated socio-political system. In Gough's analysis, however, democratic forms of government are essential to the successful operation of a capitalist economy. These separate the more coercive aspects of the polity from the economic base giving them the autonomy they need in acting in a mediating capacity to reconcile the vast diversity of interests within the capitalist system.

2.14 The connection with health care services

Lau's two themes of separation of bureaucracy from Chinese society and the nature of contact at what in this thesis will be called the "interface" are demonstrated by the historical development of medical and health services in Hong Kong. It can also be shown how these themes account for the origins of the subvention system, which has been
such a noticeable feature of the development of medical, education and social services in Hong Kong. Subvention was a mechanism for dealings at the interface.

Hong Kong's early history was marked by widespread disease. Fever, dysentery and diarrhoea at one early stage almost forced the abandonment of the Colony. Malaria and enteric diseases remained endemic throughout the 19th century. Tuberculosis remained widespread until the 1960s. In the 1890s, Hong Kong suffered severe epidemics of bubonic plague and indeed it was in Hong Kong that the plague bacillus was first identified. Annual plague epidemics occurred until 1923. As a destination for migrants up to and including today, Hong Kong has been a recipient of transmissible diseases. Each incident has had potential for conflict at the interface.

In a rapidly growing city, the connection between poor sanitation and disease was recognized by the earliest Colonial Surgeons although the specific aetiology was not known. The reasons for inaction were several, not least the poor financial position of the Colonial Government in the 19th Century. Li (1974) has shown that there was also a genuine fear of interfering with the domain of the Chinese supporting the ideas of Lau.

A full scale enquiry into sanitary conditions, ordered by London, led to the Chadwick Report in 1882. Although
far-sighted, its implementation was piecemeal and inadequate. It laid the foundations to improved health conditions which over the next 50 years were to have impact on the built environment and led to the start of major water supply programmes.

In the generally appalling environmental conditions, interventionist medicine, of any kind, is unlikely to have had impact on overall health indices. In any case, western scientific medicine was still poorly developed. It too, could be seen as an interference in the Chinese society. An assortment of traditional practitioners operated from the earliest days of the Colony and did so unhindered by Government restraint. The apparent tolerance towards traditional medicine in the primary sector that is still seen today, dates from this early period when the bureaucracy was unwilling to intervene in the Chinese society. Apart from rudimentary services for the military and the establishment of a Government Civil Hospital for the expatriate community, the Government was largely indifferent to western medical care.

No support was forthcoming for the initiatives of the Missions at this time. In 1843, the Medical Missionary Hospital of Hong Kong was set up by a doctor of the London Missionary Society but this continued operation for only ten years. There was little other mission input until
1881, when the London Missionary Society opened a clinic in the heart of the slums. Hong Kong's largest general practice dates back to 1884, but the medical registry of 1885 recorded only 10 European doctors (Mattock, op.cit.).

Following the success of their clinic, in 1887, the London Missionary Society and a prominent British trained Chinese doctor, Ho Kai, established the Alice Memorial Hospital "open to the sick of all creeds and nationalities alike". Despite the high profile of some of the hospital's supporters, including Patrick Manson - the "father of Tropical Medicine", the Government "stood aloof and gave no official recognition or assistance" (Endacott, op.cit.). Perhaps it simply was not politically imperative?

The alliance of a prominent Chinese, admittedly westernized, with an innovative and determined western organization was unusual, but was possible because the Government was not involved. Choa (op.cit.) in his biography of Ho Kai provides valuable, if uncritical, insights into the whole realm of political relations and manipulations at the interface. Ho Kai later became the first Chinese member of the Legislative Council and was eventually knighted. Ho Kai, like many Hong Kong medical philanthropists since, earned his money through land dealings. His interest in rental incomes in the worst
urban areas of Tai Ping Shan, near the Alice Memorial Hospital, led to a considerable watering down of proposed public health measures in the 1880s (Endacott, op.cit.; Crisswell, 1981). The great divergence of interests between Ho Kai and the colonial administrators battling repeated plague epidemics was side stepped by the Government in its continual bid to mediate between East and West.

Despite lack of Government support, the hospital seemed able to prosper. Its wards were immediately filled, suggesting that many Chinese were at least prepared to try western methods (Paterson, 1987, op.cit.). Six months after opening, it became home to the Hong Kong College of Medicine for Chinese, later to be the founding college of the University of Hong Kong. Patrick Manson's mission was clear and may also show why there was no Government support for medical training — it could have been regarded as politically dangerous. In the College's inaugural speech he proclaimed the need to "reform medical practice in China and to be the pioneers of science". He declared —

"The task in front of the medical reformer in China is Herculanean. There is no education system. The notions of anatomy and physiology are absurd; there is no surgery worth the name; medicines they have in superabundance, but there is no knowledge of their actions, or the diagnosis or pathology of disease. Hygiene is unknown" (cited in Mattock, 1984, op.cit., pp 9-10).
One of the initial two students at the College, was Sun Yat-sen who later led the revolution of 1911 and established the first Chinese Republic. This is more than an historical curiosity for it is indicative of the impact that western thought could have if circumstances permitted, and indicative too, of a pioneering spirit of the times. Sun, like Ho Kai, was an example of how certain individuals could exploit the interface.

2.15 The Tung Wah and the birth of the subvention system

The lack of Government support for western hospitals contrasts with its reactions to those providing hospital services using traditional Chinese methods. Again, this can be explained in terms of mediation at the interface between bureaucracy and Chinese society. Although the infant Colony was in financial difficulties, the stability of British rule enabled the emergence within twenty years of a small Chinese business elite, the "compradores", who acted as mediators in the European trading houses (Lethbridge, 1978; Crisswell, op.cit.). They hoped to translate money into social status and privilege and it was out of this class that the "Tung Wah" charity was born.

Their first tangible venture was a hospital opened in 1872, for the "care and treatment of the indigent sick", a decade before the Alice Memorial Hospital. Although this

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was exclusively for traditional methods, it received Government support. The nature of the Tung Wah Hospital's funding has a remarkable resemblance to that of subvented projects more than a hundred years later - the Government provided the site and some $15,000; the Chinese donors achieved their status by contributing a further $40,000 and the remaining $100,000 came from the Gambling Fund, a forerunner of the fund granting activities of Royal Hong Kong Jockey Club, which have contributed greatly to capital investment in medical facilities in the present century.

To gain legitimacy with both the people and the bureaucracy, the Tung Wah Board had to represent a wider sphere of Chinese interests. So guilds and "kaifongs" (street committees) were also represented. Membership was, and still is, very expensive, with each Board having to outdo its predecessor in the fund raising to avoid loss of face. As an established organization, it maintained Chinese traditions. Although, unlike many subvented organizations, it was not specifically religious, the Board has always been seen to pay tribute to Confucian philosophy.

The Tung Wah grew in strength and its influence spread into Kwangtung Province becoming a focus for many overseas Chinese donors. In the 1920s it was believed to be one of
the largest charitable organizations in the world (Lethbridge, op.cit.). Politically, it became an unofficial tribunal in public affairs, receiving and transmitting petitions. Such activities and its sheer influence have consistently engendered suspicion. In 1896, a Commission of Inquiry investigated the hospital and accusations that it was functioning as a secret society. From the 1890s onwards, Government did influence the introduction of some western medicine although in 1910, 68% of patients still chose traditional medicine. By 1921, however, this figure had dropped to 28%. By the time of the Pacific War, the Tung Wah had dropped all use of traditional drugs.

Today, the Tung Wah Group of Hospitals dominates the subvented sector controlling some 3000 beds. To some extent, its status has weakened through continued accusations of inefficiency and financial mismanagement. However, it remains an organization with which the Government has to deal delicately with. Despite receiving recurrent cost subvention, it has persistently refused to follow Government policy and charge fees in some of its hospitals. The inability of the Government to enforce its fees policy on an organization which in most respects, appears to exist at the mercy of the Government, is evidence of the continued political power of the Tung Wah Board, the Government's reluctance to intervene in Chinese society and the public feeling that there should be a
Chinese charity that provides for the destitute. This is not to say that the Tung Wah Hospitals are most consumers' first choice.

Table 2.1  
A simple classification of health services in Hong Kong

<table>
<thead>
<tr>
<th>SECTOR</th>
<th>PRIMARY</th>
<th>1ST REFERRAL LEVEL</th>
<th>2ND REFERRAL LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOVERNMENT</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>SUBVENTED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRIVATE (NON-PROFIT)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRIVATE (PROFIT)</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>PRIVATE (PROFIT)</td>
<td>X</td>
<td></td>
<td></td>
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</tbody>
</table>

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Medical and health care services in Hong Kong can be categorised as in Table 2.1 which emphasises the distinction between traditional Chinese services and western medical services. Whilst traditional services are found almost exclusively in the private primary sector, western services can also be provided by the Government (the 'Government' sector) and by non-Government agencies operating with Government subventions (the 'subvented' sector) and may be found not only at the primary level, but also at the first referral level (the specialist) and at successive referral levels (various levels of hospital admission). The private sector itself can be classified into profit-making and non profit-making divisions. For the purposes of this study, the term 'public' will refer to facilities in both the Government and the subvented sectors.

2.17 Service provision in the traditional sector

In Hong Kong, anyone of "ethnic Chinese origin" is permitted to practise traditional health care methods, providing that laws relating to western pharmaceuticals and surgical incision are observed. There is no registration of practitioners, other than standard commercial registration, and no controls over behaviour.
The consequence of Government attitudes towards the traditional sector is that in theory, supply expands to meet demand. This has to be qualified by the fact that due to an absence of controls, quality within this sector will be highly variable.

As there is no professional register, the exact numbers are difficult to ascertain. Academic research has suggested that there are probably in excess of 4,500 practitioners of a variety of skills and competence offering acupuncture, bone-setting, moxibustion (the use of a burning herb either in a container or directly on the skin, at a specified acupuncture point) and pharmaceutical services (Lee, 1975; Phillips, 1984 op. cit.) although a press report in 1985 claimed that were about 10,000 (SCMP, 13/8/85). In addition, many drug stores sell both Chinese and western medicine and in these, as in the traditional herbalist outlets, shop staff act in the roles of diagnosers and prescribers.

Traditional medicine in Hong Kong is very rarely found outside the primary sector, except for research and some experimental work into acupuncture anaesthesia and drug dependency treatment in certain hospitals. No Government funds are available to support traditional care. Utilization rates for traditional practitioners are difficult to assess. Research suggests a widespread use,
at least on an ad hoc basis and that it features in the choices made at the primary care level by a significant proportion of the population, although as Lee (1975 op. cit.) has concluded, there is a preference for western medicine in most instances.

In conclusion to this discussion on the development of the health care services, it is appropriate to note that the Government's attitudes to traditional medical practices have changed little in essence. The official attitude of the Government to traditional health care methods is one of disinterest. It remains a part of the Chinese society in which interference is avoided. The only dealings the bureaucracy has with traditional medicine occur where traditional methods impinge on areas in which the bureaucracy feels it has to impose controls. Thus, traditional herbalists who spike their drugs with steroids, or who use herbal drugs to induce abortion transgress the law.

Both Lee (1983 op. cit.) and Koo (1987, op. cit.) have argued that the Government's attitude, while being tolerant, in reality demeans traditional medicine. By not imposing regulation, standards can never be upheld. The consumer is faced with the full range of practice from impostors and incompetents through to masters of the art. Confidence is said to be lost. The unwritten message is clear - regulation is not necessary because these people
are unimportant. No attempt has been made to cater to traditional medicine needs in the proposed Hong Kong Academy of Medicine.

Other factors also need to be considered. For instance, the decline in the demand for traditional medicine in hospitals, as witnessed by the data from the Tung Wah, occurred early on, before major Government involvement in hospital care or in the promotion of western registration. The situation is confusing. Traditional care remains popular, but there is no evidence of any substantial pressure on Government to support traditional medicine, or for the idea of hospital care using traditional methods. Such hospitals exist in other Chinese communities, in and outside China, as for example in Kuala Lumpur. Although Hong Kong people utilize hospital facilities in China in significant numbers (where utilization is encouraged as it is a source of foreign currency), observations made at three hospitals in Shenzhen and Guangzhou by this author, revealed that utilization by Hong Kong patients was almost exclusively for treatment by western surgical or medical methods.

On the surface therefore, traditional medical cultures have no part to play in influencing a Hong Kong hospital philosophy. However, an indirect link can be proposed. Attitudes and behaviours arise from recourse to traditional medicine. The use of traditional medicine, for
many in Hong Kong, is highly eclectic and thrives in a mood of "experimentation". Such experimentation does not require the same types of scientific evaluation as demanded by the use of western medicine. This and other traditional notions, such as the notion of affinity between patient and practitioner varying between practitioners and diseases, contribute to the phenomenon of the "doctor shopping" culture. To a degree, this extends to hospital utilization. It contributes to the desire for access to hospitals on demand, something which has neither been denied or even effectively discouraged by the bureaucracy. Acute-general hospitals admit large numbers of patients through Accident and Emergency Departments. It is also used as a justification for poor, or no record keeping by Government hospitals.

2.18 Service provision in the western sector

In sharp contrast to the system prevailing in the traditional sector, western doctors, dentists and pharmacists have to re-register annually. Qualifications demanded are similar to those that apply in the United Kingdom. As has been shown, registration and post graduate recognition have depended heavily on criteria laid down by overseas bodies. If anything, the emphasis on restriction is increasing with other paramedicals being brought into the net. However, the effectiveness of registration can be
questioned (Lee, K.H., 1985) and there continues to be evidence of inappropriate and dangerous treatment by illegal doctors (Lim et al, 1985). Although the Government could claim that the number of complaints about illegal dentists had declined from 80 in 1979 to 37 in 1984, press reports at the same time alleged that up to 2000 illegal dentists were still operating in Hong Kong (SCMP, 8/8/85).

It is also widely believed that many China-trained "western" doctors, who are unable to obtain registration in Hong Kong, operate illegally. This number may have been reduced since the Government introduced opportunities for certain China graduates to register after examination and an externship year. But many are disqualified on language and other grounds and may continue to practise.

Therefore, practitioner to population ratios and projections of future requirements have to be treated with caution. This is a reflection of an environment in which Government control is timid and where the policing of regulations is weak, and where demand for services is high. In 1988, legally registered western doctors numbered 5,785, of whom 1,643 were in Government employment (HK Govt, 1984a). This gives an official doctor:population ratio of 1:980 (UK figures, where definitions are similar = 1:660). As with all crude statistics, care is needed in drawing conclusions. The effectiveness of the way in which doctors are used is important.
Private practice is largely concentrated in the primary sector and a majority of Hong Kong people will use private GPs at some time. Fees charged vary greatly with location of practice, reputation and specialist qualifications. In the poorer residential areas, a consultation, including drugs for 2 - 4 days, might cost the equivalent of £6 (1988) compared with £0.90 at a Government general clinic. In a well known practice in Central District, the figure could easily be ten times that of the poorer area.

Private hospitals, although expanding in size rather than number, play a fairly minor role, perhaps surprising given the nature of the Hong Kong market and its international role as an insurance centre. There is a very marked reluctance to accept the idea of individual insurance. There is a segregation of public and private hospital services. Doctors in public hospitals are generally not allowed to take on private work, as consultants can do in the United Kingdom. The opportunities for non public service doctors in private hospital work are limited. This means that many hitherto hospital specialists find themselves in new roles as "elite GPs" once they leave the public service, rarely doing hospital work. A great pool of talent and experience therefore becomes unavailable.
2.19 The Government and Primary Health Care

Some idea of how primary care is seen to be connected with secondary levels of provision is crucial to an understanding of how hospitals are expected to link with the populations they serve. As Chapter 3 will demonstrate, the MHD's concept of the service area and a hospital's responsibility for it are ill-defined. In a health care system where professional referral is erratic and unsystematic, intersectoral collaboration is weak, if not non-existent.

With Primary Care, the MHD reveals very serious problems in consistent policy formation. The problem of poor policy design and articulation is not restricted to health care services in Hong Kong although it may be more apparent in this field because of the complexity of the issues. The problems in policy formulation in Hong Kong are, in part, a reflection of the Government's lack of mandate and the established reluctance to interfere in the "Chinese society". Although technically this should not be the case, policy decisions are made largely within the bureaucracy, in this case, the MHD. Decision-makers are thus susceptible to the constraints that operate within bureaucracies.

In its declarations on Primary Care functions, the MHD
displays a lack of understanding of issues and often a misuse of terminology in the accepted sense. The Director of Medical and Health Services has stated -

"We can justifiably take pride in our provision of a primary health care system which has met the requirements as advocated by the World Health Organization to the letter" (HK Govt, 1987a, p. 1).

It is highly debateable whether the Government's primary health care services fulfil the requirements as set out in the Alma Ata Declaration (see Appendix A) and certainly the two themes of public participation and intersectoral collaboration which have been emphasised by the United Christian Hospital, have been largely ignored. The links between the general outpatient clinics and hospitals are limited to the occasional referral and often such referrals are to a hospital AED rather than to a specialist out patient department.

In the preventive field, the Government can be known to take determined and strict action at least when this does not intrude unduly into the "Chinese society". For instance, between 1980 and 1982, the Government destroyed some 100,000 dogs in an anti-rabies offensive. In 1982 alone, it fined more than 1% of the population for litter offences. In the past anti-Tuberculosis programmes have been pursued rigorously and with substantial success. In contrast its record in occupational health and pollution control, which would involve direct conflict with
industry and the work force, is poor (see Hong Kong Observers, op.cit. for discussion of Hong Kong's record on silicosis and pneumoconiosis).

The Government also appears to place little priority on its role as provider of general care services in the primary sector. The Government accepts that it has a responsibility to provide a basic "safety net" for those who are unable to afford private GP services but feels strongly that those who can afford to pay for private care should do so. A range of options is available at the primary care level in Hong Kong, depending on ability to pay. As has already been mentioned many people utilize several, if not all the options at various times; "doctor shopping" is customary and doctor loyalty is not the norm.

As its "safety net", the Government aims to provide a clinic for every 100,000 urban population (HK Govt, 1974), an example of the very rigid "planning by numbers" which characterises so much planning in Hong Kong. The clinics are large scale facilities and in the same building may be offered more specific services such as Maternal and Child care, and Family Planning (for both of which, the MHD appears to see its obligations in sense wider than simply "safety net") as well as methadone detoxification or maintenance for heroin addicts. Some clinics also maintain a number of obstetric beds.
The Government view is summed up in the words of one official who stated that—

"a Government outpatient clinic is the front line defence in the whole process of delivery of primary health care, which is designed to safeguard public health and prevent epidemics... It is not meant for anyone who comes and demands a medical check-up because he does not eat well or sleep well .." (Government Information Services press release, 26/2/82).

The priority for Government provision in the primary sector is thus basic mass screening, prevention of infectious diseases and epidemics, public health measures and support of birth control. However, as communicable diseases have become less important, the clinics have increasingly been used as a source of rudimentary curative care for those unable or unwilling to go to private GPs. Indeed, recent experience of communicable disease outbreaks, such as the 1987 cholera epidemic, show that these are much more likely to present at hospital AEDs than at Government clinics.

The Government tries to discourage use of its general clinics by those who could go elsewhere, but is unable to devise formal mechanisms or regulations to do this. The conditions that prevail, with extremely long queues and very short consultations, discourage many from presenting. Indeed, the time needed to queue may be such as to make it more economic to present at a private practice given that lost work time may mean lost pay. One pressure group has
claimed that some 25 million work hours are lost each year through queueing in "an appalling waste of time and resources" and that up to 1 in 5 patients are turned away without treatment when the doctors' quotas for the day have been filled (Hong Kong Observers, op.cit.). Despite these disincentives, the Government clinics remain very important for certain people, either because they have no option or for actual reasons of choice. In 1986, Government general outpatient clinics dealt with some 6.4 million visits giving a crude utilization rate of about 1.1/capita. This compares with 4 visits per capita to UK GPs although it must be remembered that many visits are made to private GPs in Hong Kong.

Specialist clinics may also be held at the general clinic or at special 'polyclinics' which were supposed to be provided at a rate of 1 per 500,000 population. These dealt with 10.6 million visits in 1986 and constitute the only formal link between Government and subvented hospitals and the community.

2.20 The evolution of Government health care policy

Whilst, the preceeding discussion has rightly implied a confusion in policy making, it is nevertheless still possible to identify stages in the development of health care services in Hong Kong which reflect dominant thinking
and priorities at a particular time. By examining such stages some idea may be gleaned of how prevailing philosophies of hospital care have arisen.

Sun (1986 op.cit.), has identified 5 stages in the post-War development of medical and health care services in Hong Kong. From 1946-63, the age of growing Government involvement; 1964-72, the years covered by the first White Paper on hospital development; 1973-1978, "the budding years of the Medical Development Advisory Committee"; The late 1970s and 1980s, an age of medical development; and currently, a period of diminishing Government involvement largely as a result of the 1986 Consultancy Review of hospital services. In these stages she highlights different policy emphases. From 1946-63, the emphasis was on reinforcing preventive medicine; from 1964-73 on developing outpatient facilities; from 1974 onwards, a concentration on developing hospital facilities.

Sun's study is particularly interesting in that it relates policy focus to changes in measurable health indices. She shows how indices such as post neo-natal mortality rates, declined most significantly before 1964 - that is before health care facilities became a focus of Government policy, and that since the concentration on hospital provision in the 1970s, declines have been relatively minor. A similar trend can be shown for other indices.
replicating a well known phenomenon of diminishing returns with service intervention.

In contrast to these findings, the Government frequently makes links between improved health indices and the success of its medical services. For instance the Director of MHD has declared -

"progress is further reflected in the highly satisfactory internationally recognized health indices which are good indicators generally of socio-economic progress, improvement in the environment and, above all and specifically, good measures of the quality of health care delivery" (emphasis added, HK Govt, 1987a, op.cit. p.2).

and the Governor in addressing the Legislative Council maintained that -

"Improvement in our health service can be measured by the fact that Hong Kong now has an average life expectancy of 74 for men and 79 for women. These figures are high by world standards" (SCMP. 8/10/87).

Sun's stages are broadly defined and she recognizes that at times it is difficult to identify exactly what Government policy on health care is. There seems to be a reluctance for the MHD ever to commit itself. The fervent discussions in recent years on hospital care, for example, have not involved a proper policy review but, as will be seen in Chapter 5, have centred on administrative changes. At best, policy decisions take the form of ad hoc responses to pressing problems, the most important of which is the overcrowding of inpatient facilities.
Sun has stressed that good policy making must involve a number of ordered stages - problem definition, policy formulation, policy implementation and policy evaluation. According to Sun,

"the process of making health care policies in Hong Kong is largely an incomplete one. Problem areas are not identified objectively, and policy adoption, policy formulation and policy implementation are primarily performed by the same agent, the Medical and Health Department, which is supposedly an executive department. There is a negligible amount of monitoring with regards to policy implementation and policy evaluation is non-existent" (Sun, 1986, op. cit., p. 237).

Incremental changes take place rather than the forging of major new initiatives.

In the absence of definitive policy declarations and guidelines, what exists of policy can only be inferred from an examination of published statements and by seeking some rationale in known Government actions. The underlying concern of Government health care policy is summed up in one statement from the 1964 White Paper on medical development which was the first time anything concrete was stated -

"the policy of the Government is to provide, directly or indirectly, low cost or free medical and personal health services to the large section of the community which is unable to seek medical attention from other sources" (H.K. Govt., 1964).

This highly imprecise outlook has inspired the official view since. It was echoed by the new Governor in his first
policy review at the opening of the Legislative Council Session in October 1987 when he announced -

"The Government's policy has always been to use the resources available to promote most effectively the health of the community as a whole and particularly that large section which relies on subsidised medical care" (SCMP, 8/10/87).

In 1964, Hong Kong was emerging from its main assault on TB. This was a time when large numbers of people were genuinely unable to pay for medical care. It was a time when expectations were low, when high technology was not a prerequisite for much medical care. Indeed, the new Queen Elizabeth Hospital, opened at this time, did not even have an intensive care unit.

Such an ill-defined policy might have been sufficient for those times, but over the years of growth in wealth, expectations and demand for technology, it has become increasingly inapplicable, resulting in confusion as attempts are made to apply it to modern situations. New requisites are tagged uncomfortably on at the end in an equally imprecise and problematic way. This is seen in K.L. Thong's review of his tenure as Director of Medical and Health Services when he spoke of the Government's basic objectives of "maintaining good public health and saving life and limbs for all those who need the service and in addition incorporating sophisticated and advanced services and technology" (HK Govt., 1987a, p. 5).

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As Ng has observed, whilst setting out to ensure that the poorer section of the community got adequate medical attention, the Government failed to identify whom these people were. Baulking at means testing because of the administrative difficulty, and because it was "morally indefensible and politically unacceptable" the Government, in effect, accepted that it was providing for anyone who demanded care (Ng, 1986). Thus, the evolution of the Accident and Emergency Department as the main department of many acute general hospitals, to which access is unrestricted. No fees are charged and in cases where there is any doubt, patients can, in certain hospitals, even demand admission.

As Hong Kong has become more prosperous, Government has sought to relieve the overcrowding in hospitals created by those attending by building more hospitals. This is an ad hoc reaction, out of step with the original intentions of the policy. The Government embarked on a building programme without thinking through the full implications for recurrent expenditure. The Government is now saddled with the funding of 88% of Hong Kong's hospital beds with no real means of finding the money. Ng reckons that adequate funding of the existing hospital service would consume 50% of all revenue from income tax.

A belated Government recognition of the immensity of the problem is still not matched by really clear policy
directions. Governor Wilson in his 1987 review of policy speech assured the public that the number of beds would increase "by no less than 50% in the coming decade". He recognized the heightening of public demands, declaring "we must do what we can to meet these demands" whilst acknowledging the time necessary to build and equip hospitals and to train staff, plus the increasing costs of medical care. Such costs "may lead to difficult decisions on priorities in future years" but no indication of policies for making these difficult decisions was given. Instead, the answer is to be "an organizational structure that is efficient, effective and responsive". Through this, the Government can "continue to provide subsidised medical services to one and all", this being the first time, the Government has admitted its apparently universal responsibilities (SCMP, 8/10/87).
<table>
<thead>
<tr>
<th>ASPECT OF PHILOSOPHY</th>
<th>DETAILS</th>
<th>MANIFESTATIONS</th>
<th>INFLUENCES (RELATED TO MODEL CONTRIBUTORY FACTORS)</th>
<th>VARIATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIME FUNCTION OF HOSPITAL</strong></td>
<td>Deals with disease by technological intervention in the cheapest &amp; quickest way</td>
<td>Short bed-stay in acute hospitals Acute hospitals have limited convalescent role</td>
<td>Western medicine dominant Role of medical professions Economic constraints of political-economic system</td>
<td>Long term care especially in sub-vented sector Underfunded</td>
</tr>
<tr>
<td><strong>PERSPECTIVE FOR OVERALL EVALUATION</strong></td>
<td>Short term</td>
<td>Failure to consider long term implications Evaluation on basis of each inpatient stay No/poor patient records</td>
<td>Dictates of bureaucracy Minimalist view of health Chinese culture (health perceptions/utilization behaviour)</td>
<td>1997 and the short-term syndrome</td>
</tr>
<tr>
<td><strong>DETERMINANT OF RESOURCE USE</strong></td>
<td>Expense as opposed to cost</td>
<td>Dominance of minimalist health model Desire for very large hospitals Size of hospitals determined by economics</td>
<td>Economic constraints of political-economic system Dictates of bureaucracy Public reaction to taxation</td>
<td></td>
</tr>
<tr>
<td><strong>ROLE OF TECHNOLOGY</strong></td>
<td>Highly restrained</td>
<td>Recurrent expense fear</td>
<td>Dictates of bureaucracy</td>
<td>Some separate funds for technology at university</td>
</tr>
<tr>
<td><strong>OFFICIAL ASPIRATION</strong></td>
<td>Greater expense efficiency Success in dealing with ad hoc demand</td>
<td>Criticisms of low utilization/long bed-stay Grandiose bed provision plans Desire for very large hospitals</td>
<td>Huge population growth Need to seek legitimacy</td>
<td></td>
</tr>
<tr>
<td><strong>RELATIONSHIP WITH PRIMARY CARE</strong></td>
<td>Poorly developed -hospitals seen in isolation</td>
<td>Dominance of minimalist health model</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ROLE OF SERVICE AREA</strong></td>
<td>Little function given patient behaviour Permeable Centripetal</td>
<td>No attempt to influence service area or to relate service to local needs Govt Community Nurses operate independently of hospital Poor referral links</td>
<td>Dictates of bureaucracy Low levels of local political development Traditional separation of bureaucracy from the Chinese society Patient behaviour</td>
<td>One isolated attempt to make links with service area (UCH)</td>
</tr>
</tbody>
</table>

(Continued on page 188)
<table>
<thead>
<tr>
<th>ASPECT OF PHILOSOPHY</th>
<th>DETAILS</th>
<th>MANIFESTATIONS</th>
<th>INFLUENCES (RELATED TO MODEL CONTRIBUTORY FACTORS)</th>
<th>VARIATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLIENT ACCESS</td>
<td>No official restriction</td>
<td>Free AED philosophy</td>
<td>Chinese and Christian traditions (the role of charity). Need for working class safety net.</td>
<td>United Christian Hospital charges for AED to try &amp; restrict use.</td>
</tr>
<tr>
<td></td>
<td>Nominal cost/free cost</td>
<td>Heavy overuse of AED</td>
<td></td>
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<tr>
<td></td>
<td>Up to the patient to present</td>
<td>Admission on demand for questionable cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MANAGERIAL STYLE</td>
<td>Centralized control even at Regional level</td>
<td>Top-down management</td>
<td>Colonial bureaucratic heritage - culture - role of order/&quot;face&quot;</td>
<td>Different managerial styles in subvented sector except Tung Wah where management seconded from NHD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Management by strict routines - management dominated by performance criteria devised externally to hospital</td>
<td>Role of professionals</td>
<td></td>
</tr>
<tr>
<td>PUBLIC PARTICIPATION</td>
<td>Nominal/Minimal</td>
<td>Restricted to subvented bodies</td>
<td>bureaucratic heritage</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Nominal participation on MDAC</td>
<td>Mediation at the interface between bureaucracy &amp; Chinese society</td>
<td></td>
</tr>
<tr>
<td>CARE PROVIDERS</td>
<td>A strict hierarchy of professionals with high definition of work</td>
<td>Further entrenchment of professional interests - inflexible work practices</td>
<td>Western medicine dominant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decision-making limited to clinical matters at each level</td>
<td>Suspicion &amp; opposition to innovation</td>
<td>Role of professionals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doctors get promoted into high management</td>
<td></td>
<td>Chinese culture (role of order / &quot;face&quot;)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>External pressures</td>
<td></td>
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<tr>
<td>INTERNAL ASPIRATIONS</td>
<td>Personal goals of excellence</td>
<td>Individual career histories</td>
<td>Professional interests</td>
<td>Varies in degree greatly between institutions -</td>
</tr>
<tr>
<td></td>
<td>Genuine goals of caring</td>
<td>Research &amp; innovation despite impediments</td>
<td>Hierarchical system</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Job frustration</td>
<td>Individual expressions of conscience</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Doctors’ complaints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDUCATION FUNCTION</td>
<td>Minimal</td>
<td>Education restricted to nurse training except teaching hospitals</td>
<td>Economic restraints</td>
<td>Some hospitals form unofficial/ unfunded links with universities. Some hospitals form unofficial/ unfunded links with universities. Also specialist hospitals.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff not otherwise expected to progress</td>
<td>Entrenched university interests</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Same as those for prime function</td>
<td></td>
</tr>
<tr>
<td>INNOVATION &amp; RESEARCH</td>
<td>Minimal</td>
<td>Conservative attitude</td>
<td>Economic restraints</td>
<td>Innovation may be more likely.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paranoia of expenditure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.21 Conclusion

As has been suggested, in the absence of formal declarations, delimiting a "philosophy" can be a rather speculative business. For that reason, it is not intended that a definitive statement of a prevailing Hong Kong hospital philosophy be made in this thesis. However, as the discussion in this chapter has shown, it is possible to examine certain key aspects that together might comprise a philosophy, for evidence of where emphases lie and how these are manifest in the health care service.

Building on the discussion of this present chapter, Table 2.2 summarises a number of key aspects (including those apparently emphasised by United Christian Hospital such as the role of the service area and the hospital's relationship to it), giving details of how they are manifest in Hong Kong hospitals and relating them to the contributory factors of the framework of Figure 1.2. There can be exceptions to the rule or variations and these are listed in the final column. A brief outline of the main points follows.

This chapter has emphasised the importance of financial stringency and the autocratic way in which financial standards are pursued. This is largely a product of the political economy, although this may not be wholly responsible for the traditions of the bureaucracy that
successfully effect this style of financial management. In
the case of the MHD, the management style is top-down and
highly centralized with little regard to local
circumstances. Furthermore, as seen, Hong Kong exists as a
"borrowed place" in "borrowed time". With the spectre of
1997 dominating all thinking, there is an uncertainty that
underlies so much of the functioning of society. Outlooks
have inevitably been short-term.

This accounts for the view that hospital medicine should
intervene in sickness in a cheap and quick manner. The
dominant determinants of resource use are notions of
"expense" as opposed to notions of "cost". Thus,
technology may be restricted in application because it
represents large capital outlay in the short-term and that
"dread" of MHD accountants - recurrent expense. This is
regardless of whether in the long term technology could be
cost effective. The emphasis on "expense" as opposed to
"cost" encourages a dominance of a minimalist health
outlook. Evaluation of patient care appears to concentrate
on the single episode. The standard of record keeping is
sorrowful. Patient behaviour, influenced in part at least
by traditions, does not lead to demands for anything
better - there are few pressures from referring doctors
for information as most patients are self-referred. Next
time the patient could quite easily present elsewhere.
In line with this outlook, the MHD has concentrated its efforts on large acute-general hospitals where through-put is rapid. To ensure rapid turnover of patients, a second tier of convalescent hospitals is provided (largely by the subvented sector) which are extremely poorly funded (see Chapter 3 for details). Pressures on hospitals continue unabated partly because of rapid and continued population increase. In terms of official aspirations, it is therefore not surprising that MHD gives greatest emphasis to grandiose plans for increasing bed numbers. The easiest way to achieve this is to create very large hospitals.

The MHD is clearly confused over the role of Primary Care. Officially it is seen in "safety net" terms. Its role in prevention is based on outdated experience of past situations of epidemics. Historically, the Government has always tread gingerly at the interface between bureaucracy and the "Chinese society" and so an imaginative view of relating health care to community needs and involving communities in health care activities is unlikely. In intervention terms the Government provides only the most basic technological care. This is a minimalist health outlook.

Partly as a result of this confusion, the hospital is seen in isolation. Only the MHD's specialist outpatient clinics (see Chapter 3) operate with any real links with the hospital service and even these are patchy. Referrals from
MHD general clinics are incidental and not part of any regular relationship between client and practitioner, which again is partly the product of client behaviour. To cater for this behaviour, access is generally open. Clients mostly present at AEDs which are free of charge. Overloading of AEDs leads to unnecessary admissions contributing to overcrowding in hospitals.

Linked with the poor development of Primary Care and the "mobility" or perhaps "fluidity" of "health care shopping" in Hong Kong, is the generally unimportant role of the service area — what United Christian Hospital has seemed to place such emphasis on. As Chapter 3 shows the service area for most hospitals is poorly defined, highly permeable and largely of administrative value only. Intersectoral collaboration in its fullest sense (see Chapter 1) does not exist — there appears no need for a hospital to have any knowledge of local circumstances or to develop services to cater for specific needs. The relationship with the surrounding area is a "centripetal" one.

MHD community nurses operate independently of hospitals (see Chapter 3). Involvement of the public in the running of a hospital is generally absent except for those who sit on boards of the subvented hospitals. The link between hospitals and locally elected District Boards, themselves a weakly developed concept, is virtually non-existent.
Within this system, professional groups do maintain some collective power, particularly in Government hospitals. At the University hospitals, academic interests ensure some involvement in additional training and research but these are generally absent outside the immediate academic environment. Professionals may pursue their own personal goals of excellence but the general atmosphere is not one where such goals are recognized or where any innovation is easy. Thus change within the hospital system to meet the rapidly changing needs of the population is unlikely, even if such changing needs can be identified.

Many of these key aspects can be elaborated when examining the details of hospital provision in Hong Kong and this is what Chapter 3 sets out to do. In particular, Chapter 3 assesses the association between the prevailing outlook on hospital care with spatial concerns - the location and distribution of hospital services as the interaction between hospitals and clients over space.
Chapter 3
Prevailing aspects of philosophy and the spatial characteristics of the Hong Kong hospital system

Chapter outline

Chapter 2 has identified key aspects of the prevailing philosophy of the hospital system in Hong Kong. Chapter 3 examines the geography of hospital provision in detail and the following general themes underly the discussion:

- the way in which the prevailing hospital philosophy may have influenced the pattern of hospital distribution over time;
- the argument that the philosophy does not necessarily allow for the most appropriate distribution of facilities for the population, especially a changing population;
- the way in which this inappropriate distribution is accentuated by the manner in which service areas and relationships to them are defined.

The chapter starts with a summary of the different types of hospital that exist in Hong Kong. A classification on the basis of function is given. The basic targets for provision set by the MHD are then discussed along with the rationale behind such targets which stem from MHD's preoccupation with overall provision and the "need" for more beds.

One characteristic of Hong Kong hospitals is their very large size. The geographical consequence of this is that large numbers of beds and facilities are concentrated at relatively few locations and this clearly affects the distribution of services across the urban space. The physical and economic constraints that may have encouraged this are examined as are the aspects of philosophy which may have also encouraged very large institutions.
The irregular distribution of facilities reflects a general lack of interest in location with regard to population distribution that can be traced historically. Since there is considerable inertia in hospital location (nearly half the locations date to before the Pacific War), an account of the historical development is justified. This makes the link with Sun's stages of development of health care discussed in Chapter 2.

The MHD has only paid attention to distribution of hospitals since the early 1970s when its regionalization policy was started. This policy is examined. A simple audit of hospital regions is performed by relating provision to population. The imbalances of hospital provision both between and within regions are then discussed and in connection with this, recourse is made to two detailed case-studies of hospital location decisions. These emphasise processes of decision-making (in the face of rapidly changing urban circumstances) and responses to aspects of prevailing philosophy. They also demonstrate the possibilities of choice within the constraints of the system.

As suggested in Chapter 2, the lack of interest and priority given to the service area in prevailing attitudes and the permeability of boundaries which has become associated with client behaviour and poor referral systems may make the hospital region something of administrative interest only. The predominantly "centripetal" nature of hospital service is demonstrated in an examination of the variable application of community nursing services, again demonstrating choice within constraints.
<table>
<thead>
<tr>
<th>Major acute-general hospitals with AED &amp; few convalescent beds</th>
<th>Other general hospitals</th>
<th>Small hospitals offering AED services</th>
<th>Convalescent and Rehabilitation hospitals</th>
<th>Specialty hospitals</th>
<th>Private General</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regional hospitals</strong></td>
<td>(1500-2000 beds)</td>
<td><strong>Minor acute</strong> (150-800 beds)</td>
<td><strong>Convalescent</strong> (90-1000 beds)</td>
<td><strong>Psychiatric</strong> (370-2000 beds)</td>
<td>Protestant (15-100 beds)</td>
</tr>
<tr>
<td>Queen Mary(U)</td>
<td>Queen Elizabeth</td>
<td>A M L Nethersole*</td>
<td>Our Lady Maryknoll*</td>
<td>Kowloon</td>
<td>Kowloon*</td>
</tr>
<tr>
<td>Princess Margaret</td>
<td>Kwong Wah*</td>
<td>Yan Chai*</td>
<td>Tung Wah Eastern*</td>
<td>Kowloon</td>
<td>Kowloon*</td>
</tr>
<tr>
<td><strong>Non regional</strong></td>
<td>(300-1400 beds)</td>
<td><strong>Mainly convalescent</strong> (300-1000 beds)</td>
<td><strong>Rehabilitation</strong> (80-130 beds)</td>
<td><strong>Duchess of Kent</strong> (200 beds)</td>
<td>Catholic (6125 beds)</td>
</tr>
<tr>
<td>United Christian*</td>
<td>Caritas Med Centre*</td>
<td>HK Buddhist*</td>
<td>St. John</td>
<td>Margaret Trench*</td>
<td>Grantham*</td>
</tr>
<tr>
<td>Pok Ol*</td>
<td>Kowloon</td>
<td>Tung Wah*</td>
<td>South Lantau</td>
<td>Macleho*</td>
<td>Haven of Hope*</td>
</tr>
</tbody>
</table>

**Projected/under construction**

| Tuen Mun | Pamela Youde | Haven of Hope redev* | Ruttonjee redev* | United Christian redev* | Pok Ol redev* |
| Shatin Shatin Cheshire Home | Shatin Shatin Infirmary | Shatin Shatin Infirmary | Shatin Shatin Infirmary | Shatin Shatin Infirmary | Shatin Shatin Infirmary |

Note: * denotes subvented hospital
U denotes university linked
3.1 Functions of hospitals

A broad classification of hospitals in Hong Kong, according to function, is given in Table 3.1. Within this classification there are variations in intensity of use and levels of funding, all of which have a bearing on the actual work the hospital performs. A majority of hospital beds in Hong Kong are in general hospitals of some description. These hospitals vary in the specialties they support and the time-span to which treatment is geared. The most important category in terms of resource use and patient throughput is that of the major acute-general hospitals with 24-hour AEDs. Some of these are additionally classed as "regional hospitals", officially having responsibility for certain functions for a whole region.

There is a category of smaller acute-general hospitals, supporting fewer specialties and not giving 24-hour emergency access. In effect, the private hospitals fulfill a similar function, although the nature of private hospital medicine is such that the actual work of the hospital has, at least until recently, been more dependent on external inputs of specialized services and labour than on internal organization and facilities. A significant and growing number of beds are found in the convalescent and rehabilitation category. There are relatively few specialist hospitals as such. With the exception of
psychiatric medicine, mostly concentrated in 3 very large institutions, the number of beds in specialty hospitals is small. In Hong Kong, the relatively small total population may make the running of highly specialized hospitals uneconomic. There are no plans for increasing the number of specialty hospitals. Indeed, the two remaining tuberculosis hospitals are being redeveloped as acute-general hospitals, one with an AED. Traditionally, Government efforts have been concentrated on the large acute-general hospitals and the large psychiatric hospitals leaving the smaller institutions, some of the specialist hospitals and the convalescent/rehabilitation field to the subvented sector.

3.2 A preoccupation with overall provision

Chapter 2 has shown that in response to rapid population growth, the MHD has had a pre-occupation with overall provision. In public statements, MHD officials frequently refer to crude measures such as beds/1000 population or consulting rooms/1000 population and couch their provision targets in these terms. The 1964 White Paper set a target of 4.5 beds/1000, which had not been reached by the time of the 1974 White Paper when the target was adjusted to 5.5 beds/1000. Continually increasing population has affected the attainment of such targets. Only in 1986, did the crude provision reach 4.55/1000 population.
Within the MHD, a slightly less simplistic, but still rather crude approach appears to have been adopted. In calculating the overall requirement for general hospital beds, the MHD has used a "Hospital Bed Formula" calculated as:

\[
\text{Number of beds} = \frac{\text{Discharge rate}}{\text{Population length required} \times \frac{1000 \text{ population}}{1000s} \times \text{of stay}} \times 365 \times \text{Optimum occupancy rate}
\]

(Source: MDAC minutes, 1986)

The use of an "Optimum Occupancy Rate" (OOR) is contentious. The MHD does make allowance for some variation in OOR. In Government and subvented hospitals for most specialties it is set at 85% and at 90% for TB and chest diseases. Because births in Hong Kong vary seasonally, the OOR for maternity beds in hospitals is 75%, and for beds in general clinics, 50%. These high, somewhat arbitrary OORs reflect a philosophy of maximum throughput and perhaps a lack of understanding of the nature of acute-general hospital work. Hospitals are not like hotels with beds simply to be filled. Wards are assigned specific tasks and beds are attached to staff with specific skills. An overall occupancy of only 60%, for example, may still hide the fact that one or more departments at that particular time, are operating in excess of 100% capacity with camp beds/corridor beds in use (see Table 4.7).
Length of stay data is based on past experience. This is shown along with the overall discharge rate for the years 1979-84 for both subvented and Government hospitals in Table 3.2. For the subvented hospitals, discharge rates have increased over the period and duration of stay has decreased. For the Government hospitals the picture is more erratic, the sudden changes in 1982 and 1983 being associated with automatic admission of all head injury cases (MDAC minutes, 1986).

Another crude index of "throughput" used by MHD, is the annual patient/bed utilization (Table 3.3). A variation in use even within the categories of hospital is noticeable. "Inefficient" use of hospital beds is often given as a reason for the problems that exist in Hong Kong hospitals with subvented hospitals being singled out for poor utilization rates (SCMP, 1/8/87). Variations in these indices are in practice due to many factors of which efficiency, however it may be assessed, is but one. Rates vary as a result of:

- the nature of the illnesses treated;

- admissions policy, especially the ease of admission through AED and the admission of patients for overnight observation;

- the degree of access to convalescent beds in other hospitals or the degree to which the hospital is used as a convalescent hospital by other hospitals;
Table 3.2 Overall duration of stay and discharge rates
(Source: MDAC minutes 1985)

Government hospitals
Subvented hospitals in brackets

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of inpatients</th>
<th>Overall duration of stay</th>
<th>Overall discharge rate/1000 pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979</td>
<td>260 087 (115 139)</td>
<td>8.11 (12.40)</td>
<td>53.97 (23.89)</td>
</tr>
<tr>
<td>1980</td>
<td>267 341 (119 191)</td>
<td>7.95 (11.95)</td>
<td>53.47 (23.84)</td>
</tr>
<tr>
<td>1981</td>
<td>285 025 (128 917)</td>
<td>7.66 (11.35)</td>
<td>55.52 (25.11)</td>
</tr>
<tr>
<td>1982</td>
<td>355 939 (146 548)</td>
<td>6.58 (10.45)</td>
<td>68.17 (28.07)</td>
</tr>
<tr>
<td>1983</td>
<td>339 809 (157 275)</td>
<td>7.04 (10.05)</td>
<td>64.12 (29.68)</td>
</tr>
<tr>
<td>1984</td>
<td>324 750 (157 862)</td>
<td>7.61 (9.91)</td>
<td>60.69 (29.50)</td>
</tr>
</tbody>
</table>

Notes:

Overall discharge rate = \(\frac{\text{inpatients treated}}{\text{estimate mid year population}}\)

Overall duration of stay = \(\frac{\text{bed days occupied}}{\text{inpatients treated}}\)
Table 3.3  Bed utilization of major acute-general hospitals with AED by hospital Region, 1986
(Source: H.K. Govt., 1987a)

Rates based on all beds excluding obstetrics, rehabilitation, psychiatric, infectious and mentally handicapped.

<table>
<thead>
<tr>
<th>Region</th>
<th>Beds</th>
<th>Patients treated in these beds</th>
<th>Patient/Bed p.a.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hong Kong Island</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Mary/ Tang Shui Kin</td>
<td>1311</td>
<td>86403</td>
<td>65.9</td>
</tr>
<tr>
<td>Regional rate</td>
<td></td>
<td></td>
<td>65.9</td>
</tr>
<tr>
<td><strong>Kowloon</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Elizabeth</td>
<td>1673</td>
<td>110201</td>
<td>65.9</td>
</tr>
<tr>
<td>Kwong Wah</td>
<td>1387</td>
<td>50076</td>
<td>36.1</td>
</tr>
<tr>
<td>United Christian</td>
<td>570</td>
<td>22693</td>
<td>39.8</td>
</tr>
<tr>
<td>Regional rate</td>
<td></td>
<td></td>
<td>50.4</td>
</tr>
<tr>
<td><strong>West New Territories</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caritas</td>
<td>1027</td>
<td>32811</td>
<td>31.9</td>
</tr>
<tr>
<td>Princess Margaret</td>
<td>1086</td>
<td>75895</td>
<td>69.6</td>
</tr>
<tr>
<td>Pok Oi</td>
<td>299</td>
<td>9557</td>
<td>32.0</td>
</tr>
<tr>
<td>Regional rate</td>
<td></td>
<td></td>
<td>49.0</td>
</tr>
<tr>
<td><strong>East New Territories</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prince of Wales</td>
<td>1080</td>
<td>43226</td>
<td>40.0</td>
</tr>
<tr>
<td>Regional rate</td>
<td></td>
<td></td>
<td>40.0</td>
</tr>
</tbody>
</table>
Table 3.4 Projections of bed requirements and provision 1986 - 1994

(Source: MDAC minutes, 1985)

<table>
<thead>
<tr>
<th>mid year population projection (1984) millions</th>
<th>Requirement</th>
<th>Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>bed/1000 population</td>
</tr>
<tr>
<td>1986</td>
<td>32040</td>
<td>5.8</td>
</tr>
<tr>
<td>1988</td>
<td>33870</td>
<td>5.9</td>
</tr>
<tr>
<td>1990</td>
<td>35630</td>
<td>6.1</td>
</tr>
<tr>
<td>1992</td>
<td>37350</td>
<td>6.2</td>
</tr>
<tr>
<td>1994</td>
<td>39070</td>
<td>6.5</td>
</tr>
</tbody>
</table>
- effectiveness of community nursing services which enable earlier discharge;

- levels of competence and efficiency which may or may not be related to funding.

In Hong Kong, the large acute-general hospitals generally do not have many long-term beds and this is reflected in short average in-patient stays and high annual patient/bed ratios (Table 3.3). With the regional hospitals, especially Queen Elizabeth and Queen Mary Hospitals, patients requiring longer-term treatment are transferred out to a number of hospitals - another factor which works against a defined service area. This will help to explain the higher bed utilization rates shown in Table 3.3 rather than greater "efficiency".

Projections of both provision and requirements as calculated are given in Table 3.4. Projection is always a hazardous exercise, especially in a place like Hong Kong where population growth has been rapid and unpredictable. There are other inherent weaknesses in this approach. By basing this formula on existing experience (ie discharge rates) need is equated with demand as manifest excluding consideration of unmet need. The only way future needs are anticipated is through projections in total population. As Hong Kong's population ages and changes in other respects, not least in behavioural patterns, the nature of disease
will change and this must surely have implications for discharge rates. Discharge may also be affected by changes in medical practice or by changes in quality assurance.

3.3 Hospital size - physical and economic constraints and philosophy

As Table 3.1 shows, many of the hospitals in Hong Kong are very large institutions. As elsewhere in the world, psychiatric care is centred in large hospitals, one of which was built as recently as 1973, in contravention to generally accepted modern practice. Of the 8 major acute-general hospitals providing AED services in 1986, 6 had more than 1000 beds, three having in excess of 1500 beds. Of the 12 that will be in operation by 1997, 9 will have over 1300 beds.

The difficulty in finding suitable sites has been given by Starling (1978) as reason for MHD's tendency to build very large facilities on one site, even if this means expensive land preparation works. In modern times, the locations of hospital facilities in Hong Kong, whatever their financing origins, has been determined by the Government's powerful control over land availability. All land in Hong Kong is Crown Land. Under normal circumstances, leases are bought from the Government through auction or by special grant. Once bought, auctioned leases can be exchanged and sold on the private market. Sales of leases have, in the past,
formed a significant part of the Government's income, even though new land is generally only obtainable through expensive clearance and resettlement, sea reclamation or landscaping of hill sides. The agreement between China and Britain over Hong Kong's future stipulates that no more than 50 hectares of new land can be made available each year. This has preserved the scarcity of land on the market and has held back some hospital development.

As a scarce commodity in great demand, land in Hong Kong is extremely expensive. Private hospitals are free to buy land on the open market, but this would not be economically viable. The Government policy has been to give private hospitals land leases at nominal rates (generally very small sites) on the condition that a certain percentage of the beds are available free of charge. This also affects economic viability and both these factors may help to explain the relatively unimportant role played by private hospitals in Hong Kong, although there are other factors such as the poor development of health insurance. Since 1970, only one new private hospital has been built.

The actual allocation of land in the face of competing demands within Government is a complex procedure, the details of which are not open to public scrutiny. The MHD may be allocated land directly when town plan zoning is initially carried out as, for example, in the
comprehensive planning of the New Towns. It may also be able to bid for less specific land, zoned for "Community and Institutional Use". Within the Government, there appears to be active bidding for and exchange of sites. Although allocated a certain number of sites, the MHD may not in actual practice be entitled to use all of them. If sites are not utilized within a certain time span, they may be reallocated.

Whilst the large size of hospitals can be explained in part by land availability, the building of large hospitals is encouraged by several aspects of the prevailing hospital philosophy as outlined in Chapter 2. If the prime function of a hospital is to deal with disease by technological intervention in the cheapest and quickest way, then economies of scale are of great importance. To the MHD, large facilities of over 1300 beds are efficient, despite the feeling of many who work in such hospitals that diseconomies of scale can also arise.

From public statements, it would appear that size plays an important role in the MHD's public relations. At the time of its opening in 1963, Queen Elizabeth Hospital was billed as "the biggest in the Commonwealth". The Pamela Youde Hospital, now under construction, has been widely proclaimed as "one of the largest in the world ... rivalled in size only by one in Libya and another in
Johannesburg" (SCMP, 4/8/88). Princess Margaret, Kwai Chung, Queen Elizabeth and Pamela Youde Hospitals all occupy what are clearly prestige sites in terms of prominence on the urban skyline. Perhaps this suggests a mentality that "bigger is better"? Certainly, a single large hospital investment makes a more impressive dent on those overall ratios of provision mentioned above. Unfortunately, the larger the hospital, the longer the delays in planning, building and commissioning.

The association of aspects of philosophy with large hospital size is not necessarily to suggest a cause-effect relationship. Certainly large-size institutions at a few locations are conducive to certain aspects of the philosophy. Despite an attempt to devolve administration of hospitals, the MHD has remained a highly centrally controlled bureaucracy. The concentration of facilities in a relatively small number of locations may be more conducive to centralized control. So too is the mixing of very diverse functions on the same site. While being essentially an economic measure and a response to site shortage, by preventing the development of small specialist hospitals, the MHD may be better able to avoid the conflicting demands of specialist professionals for scarce resources.
Concentration of services is also helpful in controlling the expense of technology. The concentration of technology in a few centres does encourage its maximum utilization. This can be seen with CAT Scanning hardware which is utilized very efficiently. As already discussed, this is an example of expense control. The consequent costs of defective diagnosis at the centres where CAT scans are not performed are not considered as the philosophy is geared to a short-term perspective of evaluation.

Like with technology, the philosophy of minimal educational function of the average Hong Kong hospital means that medical education is concentrated primarily at the two University hospitals. This has led to the continued expansion of Queen Mary Hospital, despite its inadequate site and its distance from the bulk of the population, instead of spreading education functions amongst smaller hospitals which would have led to their development but also to greater costs.

These aspects of philosophy can all be associated, in part at least, with dictates of the political economy. However, there are a number of other aspects, not directly related to the politico-economic system, but which also do not impede the policy of building large hospitals on few sites.
To the MHD, the actual location of hospitals within the broad area of a hospital region is a minor concern from the point of view of access (indeed, distance from AED might be beneficial as it might discourage frivolous use). By reducing personal patient costs to a minimum, maintaining free and open access to AEDs and embracing the Hong Kong customs of health care seeking, the Government assumes that all patients will present if necessary. Although regarded by most medical professionals as inadequate, the Government also provides a 24-hour "999" ambulance service which should get those most in need to an appropriate hospital.

As has been seen in Chapter 2, public participation in the running of Hong Kong hospitals is minimal and very indirect through the subvention system. Subvented bodies are Territory-wide concerns and may have little affiliation to specific areas of Hong Kong. There is thus generally little pressure for hospital facilities to be distributed in all districts. MHD faces little opposition to its policy of concentrating facilities on a few sites.

Lastly, and most significantly, is the perceived role of the service area. For most hospitals in Hong Kong service areas remain undefined. For the regional hospitals, the service area coincides with the region. Given the lack of identity of hospitals with districts, the service area is largely of administrative importance. The MHD, in its
preoccupation with overall requirements, seems uninterested in the finer details of variation between regions. Acquiescence with the prevailing health care seeking habits of the population, results in highly permeable boundaries to the service areas. It has been seen that the MHD's view of Primary Care is extremely limited and that intersectoral collaboration is not an objective. Without a clear concept of what the service area should be and with a centripetal view of the hospital's function, location within the service area, becomes of reduced importance. Thus, provision of a few very large centres as opposed to a greater number of smaller centres, is in keeping with the prevailing philosophy of hospital care.

3.4 The development of Hong Kong hospitals over time

The pattern of hospital distribution in Hong Kong has evolved over the past 100 years. Nearly half of the 34 hospitals functioning today date back to before the Pacific War as the chronology of hospitals in Table 3.5 shows. Over this century of hospital development, the population has increased rapidly and the urban area has undergone dramatic expansion. Throughout this period, there is little evidence of defined service areas for hospitals being an important consideration.
<table>
<thead>
<tr>
<th>Year</th>
<th>Establishment</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-war</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1877</td>
<td>Tung Wah (S)</td>
<td></td>
</tr>
<tr>
<td>1887</td>
<td>Alice Memorial (now Northestsole) (S)</td>
<td></td>
</tr>
<tr>
<td>1904</td>
<td>Matilda (P)</td>
<td></td>
</tr>
<tr>
<td>1911</td>
<td>Kwong Wah (S)</td>
<td></td>
</tr>
<tr>
<td>1918</td>
<td>St Paul's (P)</td>
<td></td>
</tr>
<tr>
<td>1919</td>
<td>Pok Oi (S)</td>
<td></td>
</tr>
<tr>
<td>1922</td>
<td>Tsan Yuk (G)</td>
<td></td>
</tr>
<tr>
<td>1923</td>
<td>Kowloon (G)</td>
<td></td>
</tr>
<tr>
<td>1929</td>
<td>Canossa (P)</td>
<td></td>
</tr>
<tr>
<td>1929</td>
<td>Tung Wah Eastern (S)</td>
<td></td>
</tr>
<tr>
<td>1934</td>
<td>Cheung Chau (S)</td>
<td></td>
</tr>
<tr>
<td>1935</td>
<td>Queen Mary (G)</td>
<td></td>
</tr>
<tr>
<td>1937</td>
<td>Precious Blood (P)</td>
<td></td>
</tr>
<tr>
<td>1940</td>
<td>St Teresa's (P)</td>
<td></td>
</tr>
<tr>
<td>Post-war/pre-1960s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1948</td>
<td>HK Central (P)</td>
<td></td>
</tr>
<tr>
<td>1949</td>
<td>Ruttonjee Sanatorium (S)</td>
<td></td>
</tr>
<tr>
<td>1954</td>
<td>Haven of Hope (S)</td>
<td></td>
</tr>
<tr>
<td>1955</td>
<td>Duchess of Kent (S)</td>
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<tr>
<td>1957</td>
<td>Grantham (S)</td>
<td></td>
</tr>
<tr>
<td>1960</td>
<td>South Lantau (G)</td>
<td></td>
</tr>
<tr>
<td>1961</td>
<td>Castle Peak (G)</td>
<td></td>
</tr>
<tr>
<td>1962</td>
<td>Margaret Trench (S)</td>
<td></td>
</tr>
<tr>
<td>1963</td>
<td>Queen Elizabeth (G) Baptist</td>
<td></td>
</tr>
<tr>
<td>1964</td>
<td>Caritas Medical Centre (S)</td>
<td></td>
</tr>
<tr>
<td>1965</td>
<td>Wong Tai Sin Infirmary (P)</td>
<td></td>
</tr>
<tr>
<td>1967</td>
<td>British Military (UG)</td>
<td></td>
</tr>
<tr>
<td>1969</td>
<td>Tang Shiu Kin (G)</td>
<td></td>
</tr>
<tr>
<td>1970</td>
<td>HK Buddhist (S)</td>
<td></td>
</tr>
<tr>
<td>1971</td>
<td>HK Adventist (P)</td>
<td></td>
</tr>
<tr>
<td>1972</td>
<td>Siu Lam (G)</td>
<td></td>
</tr>
<tr>
<td>1973</td>
<td>Yan Chai (S) United Christian (G) Kwan Chung (S) Princess Margaret (G)</td>
<td></td>
</tr>
<tr>
<td>1988/9</td>
<td>Tuen Mun (G)</td>
<td></td>
</tr>
<tr>
<td>1988/9</td>
<td>Shatin Cheshire Home (G)</td>
<td></td>
</tr>
<tr>
<td>Under construction/advanced planning</td>
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<td></td>
</tr>
<tr>
<td>Pamela Youde (G)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shatin Infirmary (S)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Christian redevelopment (S)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pok Oi Extension (S)</td>
<td></td>
<td></td>
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<td>Ruttonjee redevelopment (S)</td>
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<td></td>
</tr>
<tr>
<td>Queen Mary expansion (G)</td>
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<td></td>
</tr>
<tr>
<td>Others in Medical Development Programme (status uncertain)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tai Po Wethersole (S)</td>
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<td></td>
</tr>
<tr>
<td>Tsuen Wan Infirmary (G)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tai Po Infirmary (G)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Kowloon (G)</td>
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<td></td>
</tr>
<tr>
<td>Wong Chuk Hang complex for the elderly (G)</td>
<td></td>
<td></td>
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<tr>
<td>North District Hospital (G)</td>
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<td></td>
</tr>
<tr>
<td>Present day operational status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key: G = Government P = Private S = Subvented UIG = UK Government</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3.6  The development of Hong Kong hospitals

<table>
<thead>
<tr>
<th>Stages in the evolution of health care policies</th>
<th>Stage of inertia</th>
<th>First impetus for change</th>
<th>Age of growing Govt involvement</th>
<th>First White Paper</th>
<th>Budding years of the NDAC</th>
<th>Present age of medical development</th>
<th>Age of diminishing Govt involvement</th>
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</thead>
<tbody>
<tr>
<td>(after Sun, 1986)</td>
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<table>
<thead>
<tr>
<th>Health care policy focus</th>
<th>Environmental improvement</th>
<th>Reinforce preventive medicine</th>
<th>Develop out patient clinics</th>
<th>Develop hospitals</th>
</tr>
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<tbody>
<tr>
<td>(after Sun, 1986)</td>
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</table>

<table>
<thead>
<tr>
<th>Hospital evolution</th>
<th>Unco-ordinated response phase</th>
<th>Specific objective phase</th>
<th>Establish -ment of hospital philosophy phase</th>
<th>Regionalization and the reinforcement of philosophy phase</th>
<th>Phase of increasing challenge</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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From the chronology, broad phases of hospital development can be identified from generalizations of the main emphases of the time. These phases are given in Table 3.6 where it is shown how they correspond to the stages in the evolution of policy identified by Sun (op.cit.- see 2.20). It is not suggested that these phases be regarded too rigidly as they are based on completion dates of hospitals. The time between conception of the idea of a hospital and its opening can be considerable - in Hong Kong ten years is not unusual. By the time a hospital opens it may have already become a legacy of past thinking.

In the pre-War, uncoordinated response phase, the seeds of the modern disregard for service areas and the MHD's penchant for centralizing services were sown. At first, general hospitals were established by charitable bodies, mostly without Government aid, as ad hoc responses to perceived needs as they arose. Their locations were greatly influenced by site availability. The very earliest hospitals such as the Government Civil Hospital, the Tung Wah and the Alice Memorial were located where serious health problems existed and where population density was the greatest, just west of Central, Hong Kong Island (Figure 3.1). However, none could be said to have served a specific service area, but rather each was aimed at particular groups of people - the Tung Wah for those requiring Chinese medicine, the Government Civil Hospital
for westerners, the Alice Memorial for others who wanted western care.

 Whilst the Mathilda (Figure 3.1) was built to serve the needs of expatriates concentrated on The Peak, most early hospitals, especially those with clear religious affiliations, were aiming to serve communities that were not necessarily geographically concentrated. It would seem to be more a matter of chance if the developing pattern of provision were to correspond to the spread of the built-up area. The Government's investments in this phase were limited to facilities that had a centralised function. People were expected to come to them from a very wide area. Queen Mary Hospital (Figure 3.1), as the University hospital, became the main hospital for the whole of the Colony, replacing the Government Civil Hospital in 1935. Kowloon Hospital was built by the Government in 1928 to serve the whole area north of the Harbour.

 A brief war hospital phase, in which only temporary hospitals were created, was followed by the specific objective phase in which nearly all hospital building was connected with tuberculosis treatment. This was in response to the upsurge in the disease amongst the hundreds of thousands post-war refugees from China. Three TB hospitals were built as well as the Sandy Bay Children's Hospital (now The Duchess of Kent Children's
Figure 3.1  The hospitals of Hong Kong Island
Figure 3.2  The hospitals of Kowloon
Figure 3.3 The hospitals of the New Territories
Orthopaedic Hospital - Figure 3.1) built to deal with the orthopaedic consequences of TB and polio. Although these investments were made by subvented bodies, they were in line with the Government policy at the time which focussed on preventive measures (see Table 3.6), of which the fight against TB was of prime importance. With the exception of Haven of Hope (Figure 3.3), which was originally built to serve the adjoining refugee shanty town of Rennie's Mill (a very rare example of a Hong Kong hospital serving a specific spatial community), these hospitals set out to serve the Hong Kong population in general.

In the subsequent philosophy establishment phase, the Government's approach to hospital care became manifest in the opening of the large psychiatric hospital at Castle Peak in 1961 (Figure 3.3) and particularly with the opening of Queen Elizabeth Hospital (henceforth QEH - see Figure 3.2) in 1963. Ten years in planning and construction, this hospital fulfilled an openly expressed desire of the Director of MHD to maintain a concentration of medical facilities in the central Kowloon area (see 4.2). QEH occupies a site within 1.5 Km radius of both the Kwong Wah and Kowloon Hospitals, the latter of which has taken on a less acute role. QEH was intended to serve as the main acute-general for the whole of the Kowloon Peninsula and the New Territories beyond.
Sun (op.cit.) has argued that the real focus of policy at this time was the development of the clinics (Table 3.6). Certainly, it seems that having built QEH, it was then left to a variety of subvented organizations to provide acute-general services in the neglected and rural areas - Caritas Medical Centre in Sham Shui Po, Our Lady of Maryknoll in Wong Tai Sin (Figure 3.2) and the Fan Ling Hospital in the rural township of Fanling (see Figure 3.3). The Tung Wah Group built infirmary facilities on both sides of the Harbour. However, towards the end of this phase, the Government was forced to confront the weaknesses of concentrating Accident and Emergency services in so few centres. Increasing problems of access to the only Accident and Emergency Department (AED) on Hong Kong Island at Queen Mary (QMH), led the MHD to build the very small Tang Shui Kin Hospital, nearer to the main concentrations of population on Hong Kong Island, in effect as an additional AED for QMH.

The 1970s, especially after the Second White Paper and the regionalization of hospital services marked a distinct period in which the philosophy established with the opening of QEH became further entrenched. The beginning of the regionalization and reinforcement of philosophy phase was marked by the completion of two very large Government hospitals - the acute-general Princess Margaret Hospital (PMH) and the Kwai Chung Hospital, a psychiatric
hospital on an adjoining site (Figure 3.3). There was a large increase in hospital beds elsewhere with the opening of three subvented general hospitals, all of which were away from the centre.

The Government's second White Paper in 1974 laid down the plans for future hospital expansion and made proposals for the management of hospitals by regions. The White Paper effected a change in emphasis in that it committed the Government to providing facilities in line with the major population changes that were occurring in the New Territories. Whilst this might have been a positive sign of a change in attitudes towards service areas, it is argued below that these proposals in effect, reinforced the MHD's philosophy of hospital care. For one, the MHD could not conceive of the possibility of hospitals starting off small with a built-in ability to expand. It remained pre-occupied with very large hospitals, which proved, once again, to take excessive amounts of time to build. Given that the efforts in the subvented sector were now exhausted, no more hospitals were completed for the rest of the 1970s, despite the policy emphasis being on hospital construction. It was not until the middle of the succeeding decade, that the next acute-general hospital came on stream.

By the mid 1980s, with the weaknesses in the organization of hospitals becoming very apparent and public demands for
better provision becoming more vocal, it is conceivable that the bases on which Hong Kong's hospitals have been built and operated will be questioned in a phase of increasing challenge. The major consultancy review of hospitals instigated in 1976 (H.K. Govt., 1986a, op.cit.) marks the beginning of this challenge. Given the great cost of the latest projects (the construction of the new Pamela Youde Hospital and the renovation and expansion of the United Christian Hospital together costing in excess of £300 million), the days of the mega hospital may be over. From 1990, the provision of hospital services will cease to be the responsibility of the MHD and the new Hong Kong Hospital Authority, formed in 1990, will take over control. It will inherit a spatial pattern of hospital provision that has been substantially influenced by the prevailing attitudes of the past 30 years in particular.

Some of the spatial pattern the new hospital authority will inherit will consist of projects either being constructed or currently in the advanced planning stage. These will be legacies of former policies and thinking. Proposed projects and projects under development are given in Table 3.1. The MHD has proved reluctant to disclose the exact status of each project. Projects in the Medical Development Programme are placed in categories according to their status in the Public Works Programme (for Government projects) or in accordance with funding
arrangements (for subvented projects). A project that is only at an outline stage of development is classed as "Category C". "Category B" represents a more advanced stage of planning and intention, but it is only when a project is elevated to "Category A" that there is any assurance of its fruition. Major projects such as the East Kowloon Hospital have remained in Category C for 15 years. This has not stopped MHD claiming that the East Kowloon Hospital would be built by 1995 (SCMP, 1/8/89). There is therefore a potential for inaccuracy in MHD projections of future provision which are based on all proposed projects regardless of their status in the Medical Development Programme.

3.5 Regionalization of hospital services

The concept of regional organization introduced in the 1974 White Paper was especially concerned with ensuring that:

- patients were treated at facilities most appropriate to their ailments;

- maximum use was made of hospital beds;

- AED services were improved (H.K. Govt., 1974, op.cit.).
The White Paper also emphasised the need for new hospital developments in the new urban areas of the New Territories. Initially it was intended that there would be 4 regions - Hong Kong Island, East Kowloon, West Kowloon and the New Territories with the latter being split into East and West when suitable hospital facilities came on stream (see Figure 3.4). Each region was to be served by:

- a "regional hospital" which would be a major acute-general hospital capable of providing the region with all major specialist services;

- one or more "district hospitals" which would provide basic hospital services admitting patients who did not warrant referral directly to the regional hospital for specialist treatment. District hospitals would also receive patients from the regional hospital for the later stages of their treatment (a role that was later to be given to specifically designated convalescent or infirmary hospitals);

- one or more specialist clinics or polyclinics to provide the necessary support of outpatient specialist services;

- an unspecified number of general outpatient clinics to provide general clinic and preventive health services (MDAC papers, 1984; MHD communication, 1988).
Figure 3.4  The hospital regions, 1974
The regional hospitals were designated as Queen Mary for Hong Kong Island and Princess Margaret for the New Territories. Kwong Wah, although in West Kowloon was to have been the regional hospital for East Kowloon until the unspecified completion date of an East Kowloon Hospital. Queen Elizabeth was to act as a regional hospital for West Kowloon (see Figure 3.2) However, in the event, Kwong Wah was never regarded as capable of assuming a regional role and Kowloon has continued to be operated as one single region with an overloaded Queen Elizabeth Hospital as the regional hospital. Thus, only three regions existed until the full commissioning of the Prince of Wales Hospital in Shatin in 1985 and the subsequent division of the New Territories into two regions more than ten years after the White Paper. The MHD has also been very slow in setting up the separate, relocated bureaucracies needed to manage the regions. Since it has appeared to keep important decision-making at the centre, the whole exercise may have merely added another bureaucratic tier to the management of hospitals, the benefits of which are difficult to ascertain.

In the case of the district hospitals, regionalization was beset with fundamental conceptual difficulties. These are partly the product of the official hospital philosophy. It is not surprising, given a philosophy that places such little emphasis on the service area, that the term "district" has no meaning in a spatial sense. District
hospitals are not expected to have defined service areas. There is no official relationship between what the MHD calls a district hospital and the City Districts, the political units into which the urban area is divided. There is no need for this, given a philosophy of minimal public participation.

The district hospitals are seen as contributing to overall needs (theoretically of the region) rather than to any specific requirements of a locality, the possible existence of which do not appear to be recognized by the MHD. If the regional scheme had been adhered to, to the letter, the district hospitals would have existed simply to permit the regional hospitals to function at their most efficient. As has been seen, in Hong Kong this is assessed with a short term perspective centring on bed utilization and expense limitation.

However, the scheme was never adhered to strictly. In reality the district hospitals have a variety of roles. Although they have generally been hospitals in the subvented sector, there is very little else that is common between them. They all date from before the 1974 White Paper and have tended to continue the roles they had already established. Caritas Medical Centre (CMC) in Sham Shui Po and United Christian Hospital (UCH) in Kwun Tong, for example (Figure 3.2), were built with specific intentions of providing a comprehensive hospital service.
including AED. It is unclear what exactly the MHD envisaged by "basic hospital services" in its definition of a district hospital but it is evident that these two hospitals maintain the variety of specialties one would expect in district general hospitals in the United Kingdom (see for example Table 4.7). As MHD has discovered itself, at its very small Tang Shui Kin and Fan Ling Hospitals, an AED cannot be run effectively without comprehensive specialist back up on site.

Since the 1974 White Paper, and in spite of it, UCH, CMC and to an increasing extent, Pok Oi Hospital (POH) in Yuen Long, have developed as fully fledged acute-general hospitals in their own rights taking no convalescent patients discharged from the regional hospitals as originally intended. In this, however, they have been particularly hamstrung by a lack of facilities, inferior funding (and serious subsequent staffing limitations), a lack of back-up convalescent beds in other hospitals and no access to the Government's specialist polyclinics and general clinics. This remains the case despite a recent assurance by the Director of MHD that under regionalization "hospital and clinic facilities situated in a common geographical area are grouped together to form an integrated network of services" (H.K. Govt., 1987a, p.16, emphasis added). The only effective link between these key subvented district hospitals and Government
hospitals is that patients are transferred to the regional hospital, either for clinical reasons, but just as likely because the district hospitals are full.

In an attempt to explain the confused role of the district hospitals, MHD has claimed that unexpected rapid increases in population, especially through in-migration between 1979 and 1981 (when population increased by 577,000 instead of the projected 218,000), put additional pressure on acute beds and thus forced a modification of policy (MDAC papers, 1984). Pressures on acute beds continue and Government has now become involved in building very large acute-general district hospitals, firstly at Tuen Mun in the West New Territories (Figure 3.3), completed in 1988 (although by 1989, still not on stream) and at Chai Wan, in Eastern District in the Hong Kong Island Region, scheduled to open in 1996 (Figure 3.1). Current MHD thinking appears to suggest that a new class of convalescent/infirmary hospital is needed, 2 of which are currently under construction in Shatin new town, with another 2 "planned".

The MHD's failure to approach health care and hospital care in a integrated manner is reflected in one other unsatisfactory aspect of the regional system - the fact that less than half of Hong Kong's hospitals are covered by the referral aspects of the scheme. Understandably, the 12 private hospitals are not involved, but neither are 3
subvented general hospitals - the Alice Ho Mui Ling Nethersole, Tung Wah and Our Lady of Maryknoll Hospitals, nor most of the specialty hospitals. Whilst these hospitals may now come under the bureaucratic control of the regional bureaucracies, they are still expected to function "independently" on a Territory-wide basis.

3.6 Regional variations

In Hong Kong, there is a marked tendency for Government to approach matters as if the territory was uniform throughout. Hong Kong does, after all, have a relatively small population - still less than that of London. Additionally, the very high densities in the older urban parts often make it difficult to identify distinct social areas. In the older urban areas, environmental conditions are poor throughout. In the New Towns, their similar vintage and building techniques have produced an impression of uniformity. The development of democratic systems in Hong Kong is still very weak and although the structure at the District level is now established, this has yet to develop in a way to achieve distinct identities for each city district.

On closer scrutiny, differences between the hospital regions, can be identified. In the New Territories, distance still has a very different meaning than in the
older parts of Kowloon for instance. Population densities are considerably lower, even in the New Towns. As Figure 3.5 demonstrates, age-sex structures are not exactly the same. As an area of recent settlement, the New Territories, both East and West have younger populations than the more established Hong Kong Island and Kowloon. It is possible that these differences could be translated into differential demand at the various hospitals of the regions.

Rapid, but varying population growth has changed the relative importance of the regions. Before the Pacific War, the population of Hong Kong was concentrated on the north shore of Hong Kong Island and on the Kowloon Peninsula. The New Territories, (only acquired in 1898), were isolated from the main urban areas both physically and socially. Sensitivity over land holding prevented any major development of the area, as did problems of physical access.

In the post-War influxes of migrants from China, large shanty towns sprung up in the fringe areas of Kowloon. Large reclamation and landscaping projects in this area followed from the late 1950s onwards with huge public housing programmes in Wong Tai Sin, Sham Shui Po and Kwun Tong. Development also occurred in Tsuen Wan, from the 1950s. The growth of these areas is shown in Figures 3.6.1 and 3.6.2 and Table 3.7.
Figure 3.5 Age-sex structures of the hospital regions

KOWLOON

MALE

FEMALE

EAST NEW TERRITORIES

WEST NEW TERRITORIES

HONG KONG ISLAND

THOUSANDS

THOUSANDS

- 233 -
Figure 3.6.1  
Population growth in the hospital regions

Figure 3.6.2  
Changing population distribution between hospital regions, 1981-1981
Table 3.7  
Population of the Hong Kong, 1961 - 1986  
By hospital region  
(Source: H.K. Govt., 1972; H.K. Govt., 1987b)

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</tr>
</thead>
<tbody>
<tr>
<td>Hong Kong Island</td>
<td>1,004,875</td>
<td>1,030,970</td>
<td>996,183</td>
<td>1,026,870</td>
<td>1,183,621</td>
<td>1,117,560</td>
</tr>
<tr>
<td>Kowloon</td>
<td>1,578,026</td>
<td>2,032,830</td>
<td>2,194,853</td>
<td>2,378,480</td>
<td>2,450,187</td>
<td>2,301,691</td>
</tr>
<tr>
<td>West New Territories</td>
<td>218,625</td>
<td>329,780</td>
<td>446,783</td>
<td></td>
<td>915,555</td>
<td>1,148,070</td>
</tr>
<tr>
<td>East New Territories</td>
<td>191,320</td>
<td>212,820</td>
<td>218,917</td>
<td></td>
<td>387,450</td>
<td>733,096</td>
</tr>
</tbody>
</table>

(Source: H.K. Govt., 1972; H.K. Govt., 1987b)
Most of the New Territories remained a rural backwater until the late 1960s when the Lion Rock Tunnel connected Kowloon to Shatin. In the early 1970s, 3 New Towns were designated (Tsuen Wan, Shatin and Tuen Mun – Figure 3.3) which developed rapidly (Figure 3.6.1). In the 1980s, the old market towns (Tai Po, Yuen Long and Sheung Shui) were redesignated as New Towns and a further New Town at Junk Bay was started. Developments in the northeast and southwest of Hong Kong Island away from the traditional concentrations on the northern shoreline have also been dramatic.

These developments have shifted the emphasis away from the established areas of population. At the same time the total population of Kowloon has now begun to decline whilst Hong Kong Island's population, after having declined slightly has now stabilised. Given that hospital regions are relatively large areas, consideration only of total population change masks changes that might occur within the regions. An example of internal change is given in Figure 3.7 which shows the changes in population of Census Districts over the 1970s for the older urban areas. The prevailing hospital philosophy in Hong Kong has made it difficult for the system to accommodate changes both between regions and within regions.
Figure 3.7 Population change in the older urban areas, 1971-1981
3.7 Comparison of regional provision

It is possible to relate facilities provided in each region to regional population totals in order to assess relative provision across Hong Kong. There are, however, limitations to this approach which will be discussed below. The provision of beds by specialty and hospital for each region in 1986 is given in Tables 3.8 and rates have been calculated using data from the 1986 by-census. Some of these are crude rates, although for obstetrics and gynaecology, sex and age of population are taken into account while for paediatrics and geriatrics, age is considered. There is variation between the regions especially for internal medicine and surgery. Hong Kong Island has twice the level of internal medicine provision compared with East New Territories, which itself has a third of the surgical provision of Hong Kong Island.

The differences between the regions are less for orthopaedics, obstetrics and gynaecology although HK Island does seem to be the most favoured region. It is in the provision of long term chronic beds that the differences are most marked. Psychiatric care is concentrated almost entirely in West New Territories which also has the only hospital provision for the mentally handicapped. This region is also particularly well endowed with geriatric beds whilst Hong Kong Island has none.
Table 3.8  Hospital bed provision by hospital region
(calculated from data from H.K. Govt., 1987a, 1987b and 1987c)

<table>
<thead>
<tr>
<th></th>
<th>HONG KONG</th>
<th>KOWLOON</th>
<th>WEST NEW TERRITORIES</th>
<th>EAST NEW TERRITORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>POPULATION</td>
<td>1,175,997</td>
<td>2,301,691</td>
<td>1,148,070</td>
<td>733,096</td>
</tr>
<tr>
<td>% AGED 65 AND OVER</td>
<td>8.66%</td>
<td>8.27%</td>
<td>5.77%</td>
<td>6.66%</td>
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<tr>
<td>% UNDER 15 YEARS</td>
<td>20.79%</td>
<td>20.67%</td>
<td>27.57%</td>
<td>28.53%</td>
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<tr>
<td>TOTAL BED/1000 POP</td>
<td>4.35</td>
<td>3.08</td>
<td>6.19</td>
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<td>INTERNAL MEDICINE</td>
<td>1.07</td>
<td>0.71</td>
<td>0.55</td>
<td>0.50</td>
</tr>
<tr>
<td>SURGERY</td>
<td>0.90</td>
<td>0.61</td>
<td>0.51</td>
<td>0.33</td>
</tr>
<tr>
<td>ORTHOPAEDICS &amp; TRAUMA</td>
<td>0.37</td>
<td>0.38</td>
<td>0.32</td>
<td>0.20</td>
</tr>
<tr>
<td>MENTALLY ILL</td>
<td>0.01</td>
<td>0.08</td>
<td>3.01</td>
<td>0.10</td>
</tr>
<tr>
<td>MENTALLY HANDICAPPED</td>
<td>0.00</td>
<td>0.00</td>
<td>0.44</td>
<td>0.00</td>
</tr>
<tr>
<td>TB &amp; CHEST</td>
<td>0.60</td>
<td>0.13</td>
<td>0.00</td>
<td>0.20</td>
</tr>
<tr>
<td>OTHER INFECTIOUS</td>
<td>0.00</td>
<td>0.00</td>
<td>0.20</td>
<td>0.00</td>
</tr>
<tr>
<td>REHABILITATION &amp; CHRONIC</td>
<td>0.18</td>
<td>0.03</td>
<td>0.00</td>
<td>0.20</td>
</tr>
<tr>
<td>RADIOTHERAPY &amp; ONCOLOGY</td>
<td>0.18</td>
<td>0.04</td>
<td>0.06</td>
<td>0.11</td>
</tr>
<tr>
<td>OBSTetrics (beds/1000 females aged 15-44)</td>
<td>1.57</td>
<td>1.26</td>
<td>1.33</td>
<td>1.37</td>
</tr>
<tr>
<td>Gynaecology (beds/1000 females aged 10 and over)</td>
<td>0.37</td>
<td>0.24</td>
<td>0.26</td>
<td>0.24</td>
</tr>
<tr>
<td>Paediatrics (beds/1000 population under 15 years)</td>
<td>1.03</td>
<td>1.48</td>
<td>0.97</td>
<td>0.91</td>
</tr>
<tr>
<td>Geriatrics (beds/1000 population aged 65 &amp; over)</td>
<td>0.00</td>
<td>0.70</td>
<td>5.80</td>
<td>2.03</td>
</tr>
</tbody>
</table>

(All rates are for beds/1000 population unless specified otherwise)
Table 3.9 **Beds in acute-general hospitals with AEDs**

Measured as rates per region population

(Source: H.K. Govt. 1987a)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Medicine</th>
<th>Surgery</th>
<th>Orthop</th>
<th>Obstet</th>
<th>Gynaec</th>
<th>Paedia</th>
<th>U/C Ca</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Mary &amp; Tang Shui Kin</td>
<td>353</td>
<td>329</td>
<td>47</td>
<td>64</td>
<td>107</td>
<td>135</td>
<td>57 35</td>
</tr>
<tr>
<td>HK Is Total</td>
<td>353 0.30</td>
<td>329 0.29</td>
<td>47 0.13</td>
<td>64 0.21</td>
<td>107 0.21</td>
<td>135 0.55</td>
<td>57 35</td>
</tr>
<tr>
<td>Queen Elizabeth</td>
<td>385</td>
<td>406</td>
<td>176</td>
<td>188</td>
<td>94</td>
<td>315</td>
<td>109 28</td>
</tr>
<tr>
<td>Kwong Wah</td>
<td>373</td>
<td>389</td>
<td>106</td>
<td>188</td>
<td>60</td>
<td>206</td>
<td>163 10</td>
</tr>
<tr>
<td>United Christian</td>
<td>127</td>
<td>140</td>
<td>100</td>
<td>47</td>
<td>45</td>
<td>88</td>
<td>23 7</td>
</tr>
<tr>
<td>Kowloon Total</td>
<td>885 0.38</td>
<td>935 0.41</td>
<td>362 0.17</td>
<td>500 0.20</td>
<td>199 0.21</td>
<td>609 1.28</td>
<td>295 35</td>
</tr>
<tr>
<td>Caritas Med Centre</td>
<td>198</td>
<td>157</td>
<td>102</td>
<td>105</td>
<td>70</td>
<td>88</td>
<td>34 0</td>
</tr>
<tr>
<td>Princess Margaret</td>
<td>275</td>
<td>259</td>
<td>214</td>
<td>90</td>
<td>39</td>
<td>184</td>
<td>8 8</td>
</tr>
<tr>
<td>Pok Oi</td>
<td>129</td>
<td>93</td>
<td>51</td>
<td>32</td>
<td>0</td>
<td>26</td>
<td>0 0</td>
</tr>
<tr>
<td>NT West Total</td>
<td>602 0.53</td>
<td>509 0.44</td>
<td>367 0.32</td>
<td>227 0.20</td>
<td>109 0.24</td>
<td>298 0.94</td>
<td>42 8</td>
</tr>
<tr>
<td>Prince of Wales</td>
<td>221</td>
<td>240</td>
<td>136</td>
<td>138</td>
<td>65</td>
<td>185</td>
<td>31 8</td>
</tr>
<tr>
<td>NT East Total</td>
<td>221 0.32</td>
<td>240 0.35</td>
<td>136 0.20</td>
<td>128 0.71</td>
<td>65 0.22</td>
<td>185 0.89</td>
<td>31 8</td>
</tr>
</tbody>
</table>

Obstetric rates = beds/1000 female population aged 15-44
Gynaecology rates = beds/1000 female population aged 10 & over
Paediatric rates = beds/1000 population aged <15

Surgical, Internal medicine, orthopaedic rates = beds/1000 pop

U/C = unclassified
Ca = casualty and observation beds
### Table 3.10 Specialist Clinic Attendance, 1986

(Source: H.K. Govt., 1987a)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>No of specialist clinic attendances per admission</th>
<th>Total No of specialist clinic attendances for region</th>
<th>Regional rate specialist clinic attendances per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HK ISLAND</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Mary</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tang Shui Kin</td>
<td>12.7*</td>
<td>2 450 112</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>KOWLOON</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Elizabeth</td>
<td>4.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kwong Wah</td>
<td>6.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Christian</td>
<td>9.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 194 462</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>WEST NEW TERRITORIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caritas</td>
<td>5.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Princess Margaret</td>
<td>5.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pok Oi</td>
<td>1.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 008 779</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>EAST NEW TERRITORIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prince of Wales</td>
<td>9.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>999 249</td>
<td>1.4</td>
</tr>
</tbody>
</table>

* Tang Shui Kin (TSK) acts as an OPD for Queen Mary (QMH)*
These rates are based on official classification of bed use and do not reflect the actual intensity of use. A bed may be classed as "surgical" for instance at both an acute-general hospital and at a longer term convalescent/infirmary hospital. In order to reduce this distortion and to achieve a comparison between hospitals showing some similarity in level of care, those acute-general hospitals supporting a 24-hour AED service have been isolated and provision in these hospitals is given in Table 3.9. (Queen Mary and Tang Shui Kin here are regarded as operating as one hospital and two AEDs). For these kinds of acute beds, the variation in provision between the four regions is much less apparent. However, as has already been seen (Table 3.3), even within this supposedly similar group, actual throughput of patients varies. Whatever the reasons, the actual utilization of the beds in the major acute-general hospitals varies noticeably between the regions with the greatest difference being between Hong Kong Island and East New Territories. One further indication of varying hospital bed usage may be implied from Table 3.10 which shows the variations in per capita specialist clinic attendance between the regions. The per capita attendance for the East New Territories is the lowest.

There are major qualifications to note with this kind of analysis. For one, with the "open access" approach to
hospital care, and with a majority of patients, originally presenting on their own initiative at AED, there can be no guarantee that a particular hospital actually serves the population of its region. Regional boundaries are permeable and cross-boundary movements occur even across pronounced physical boundaries such as the Harbour. There is little data on patient origin but that which is available does suggest a tendency to use "local" facilities, although there is considerable movement of some patients. Research into patient origin at United Christian Hospital (UCH) in Kwun Tong revealed that 85.1% of patients come from within the Kwun Tong District (Chapter 4). At UCH, only Kwun Tong residents are allowed admission for obstetrics, but this kind of residential qualification is unique to this hospital and to only one department and this data was excluded from the analysis. An MHD study in 1982 produced comparative data contained in Table 3.11. These data may reflect a tendency to present at the hospital nearest to home, despite the Hong Kong propensity to "shop around" in health care seeking.

One additional note of caution concerns the data for Kowloon and West New Territories. Caritas Medical Centre, an acute-general hospital with AED, officially operates as within the West New Territories region, despite being clearly located within the Kowloon Region. If there was some control over who uses which hospital, then there
Table 3.11  
Inpatient origin at some major hospitals  
(% of total inpatients)

<table>
<thead>
<tr>
<th>Hospital Region</th>
<th>Hospital</th>
<th>QMH</th>
<th>QEH</th>
<th>PMH</th>
<th>UCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hong Kong Island</td>
<td>QMH</td>
<td>81.1</td>
<td>2.0</td>
<td>2.4</td>
<td>1.6</td>
</tr>
<tr>
<td>West Kowloon</td>
<td>QEH</td>
<td>10.7</td>
<td>49.9</td>
<td>17.9</td>
<td>6.9</td>
</tr>
<tr>
<td>East Kowloon</td>
<td>PMH</td>
<td>25.1</td>
<td>5.0</td>
<td>87.6</td>
<td></td>
</tr>
<tr>
<td>West NT</td>
<td>UCH</td>
<td>6.6</td>
<td>4.8</td>
<td>70.9</td>
<td>1.4</td>
</tr>
<tr>
<td>East NT</td>
<td></td>
<td>17.1</td>
<td>2.8</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td>1.6</td>
<td>1.1</td>
<td>1.0</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Data for Queen Mary (QMH), Queen Elizabeth (QEH) and Princess Margaret (PMH) for 1982
Data for United Christian (UCH) from 1981
Region in which hospital is located is underlined

Note:

Prince of Wales (ENT) was not in operation at this time

(Source: MDAC minutes 1984 and UCH study - see 4.10)
### Table 3.12 Work of major AEDs, 1986

(Source: H.K. Govt., 1987a)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>% of all admissions thru AED</th>
<th>Traumatic as % of total attendance</th>
<th>% of traumatic attenders admitted</th>
<th>% of non traumatic attenders admitted</th>
<th>Total attendance &amp; No./1000</th>
<th>Total admissions thru AED &amp; No./1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Mary</td>
<td>65.9</td>
<td>22.6</td>
<td>35.8</td>
<td>54.1</td>
<td>116623</td>
<td>59743</td>
</tr>
<tr>
<td>Tang Shui Xin</td>
<td>87.3</td>
<td>46.2</td>
<td>5.6</td>
<td>2.3</td>
<td>99810</td>
<td>3818</td>
</tr>
<tr>
<td>HK ISLAND</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>186.6</td>
<td>54.1</td>
</tr>
<tr>
<td>Queen Eliz.</td>
<td>62.7</td>
<td>30.1</td>
<td>29.4</td>
<td>38.0</td>
<td>231975</td>
<td>82109</td>
</tr>
<tr>
<td>Kwong Vah</td>
<td>72.8</td>
<td>22.2</td>
<td>14.0</td>
<td>40.0</td>
<td>128517</td>
<td>43965</td>
</tr>
<tr>
<td>United Christ.</td>
<td>60.0</td>
<td>29.6</td>
<td>7.8</td>
<td>16.1</td>
<td>125401</td>
<td>17114</td>
</tr>
<tr>
<td>KOWLOON</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>211.1</td>
<td>62.2</td>
</tr>
<tr>
<td>Caritas</td>
<td>55.0</td>
<td>16.7</td>
<td>17.9</td>
<td>38.9</td>
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<td>23040</td>
</tr>
<tr>
<td>Princess Mary</td>
<td>67.3</td>
<td>28.2</td>
<td>17.3</td>
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<td>64016</td>
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<td>62.1</td>
<td>30.6</td>
<td>3.3</td>
<td>28.2</td>
<td>35318</td>
<td>7264</td>
</tr>
<tr>
<td>WEST NEW TERRITORIES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>215.1</td>
<td>62.2</td>
</tr>
<tr>
<td>Prince of Wales</td>
<td>46.9</td>
<td>27.7</td>
<td>8.0</td>
<td>27.4</td>
<td>110204</td>
<td>24307</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>150.3</td>
<td>35.2</td>
</tr>
</tbody>
</table>
Table 3.13

Attendance at AEDs, 1986
(Source: H.K. Govt., 1987a)

(Percentages of all cases attending)

<table>
<thead>
<tr>
<th></th>
<th>QEH</th>
<th>TSE</th>
<th>QEH</th>
<th>KHH</th>
<th>UCH</th>
<th>CKC</th>
<th>PKH</th>
<th>POH</th>
<th>POWH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traumatic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault</td>
<td>8.2</td>
<td>8.7</td>
<td>18.3</td>
<td>6.7</td>
<td>8.4</td>
<td>11.0</td>
<td>7.4</td>
<td>8.8</td>
<td>5.5</td>
</tr>
<tr>
<td>Traffic</td>
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<td>9.5</td>
<td>20.2</td>
<td>5.7</td>
<td>7.4</td>
<td>11.3</td>
<td>6.2</td>
<td>8.7</td>
<td>7.6</td>
</tr>
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<td>29.9</td>
<td>35.8</td>
<td>42.7</td>
<td>29.7</td>
<td>49.2</td>
<td>14.7</td>
<td>32.7</td>
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<td>Domestic</td>
<td>48.2</td>
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<td>49.3</td>
<td>22.5</td>
<td>47.0</td>
<td>30.5</td>
<td>47.4</td>
<td>45.5</td>
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<td>4.8</td>
<td>14.1</td>
<td>13.1</td>
<td>2.5</td>
<td>19.0</td>
<td>1.0</td>
<td>6.7</td>
<td>10.4</td>
<td>8.7</td>
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<td><strong>Non-traumatic</strong></td>
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<td></td>
<td></td>
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<tr>
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<td>6.4</td>
<td>0.3</td>
<td>0.1</td>
<td>4.7</td>
<td>5.1</td>
<td>0.0</td>
<td>0.4</td>
</tr>
<tr>
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<td>1.7</td>
<td>7.9</td>
<td>0.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Medical</td>
<td>43.7</td>
<td>47.8</td>
<td>30.5</td>
<td>48.4</td>
<td>49.4</td>
<td>352.0</td>
<td>42.3</td>
<td>44.7</td>
<td>40.0</td>
</tr>
<tr>
<td>Surgical</td>
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<td>15.7</td>
<td>015.8</td>
<td>14.5</td>
<td>11.5</td>
<td>16.5</td>
<td>18.9</td>
<td>11.2</td>
<td>14.7</td>
</tr>
<tr>
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<td>1.8</td>
<td>6.2</td>
<td>0.7</td>
<td>0.4</td>
<td>0.2</td>
<td>2.7</td>
<td>1.3</td>
<td>1.2</td>
</tr>
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<td>5.1</td>
<td>6.6</td>
<td>3.0</td>
<td>2.8</td>
<td>4.1</td>
<td>4.0</td>
<td>1.6</td>
<td>3.7</td>
</tr>
<tr>
<td>Paediatric</td>
<td>14.8</td>
<td>14.4</td>
<td>19.2</td>
<td>18.1</td>
<td>26.6</td>
<td>19.5</td>
<td>15.1</td>
<td>32.8</td>
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</tr>
<tr>
<td>Psychiatric</td>
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<td>1.8</td>
<td>1.0</td>
<td>0.1</td>
<td>0.6</td>
<td>0.0</td>
<td>0.8</td>
<td>1.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>7.5</td>
<td>6.4</td>
<td>5.7</td>
<td>7.1</td>
<td>3.5</td>
<td>5.4</td>
<td>8.4</td>
<td>2.1</td>
<td>6.3</td>
</tr>
<tr>
<td>Dental/Ophthalmology/Ear Nose Throat</td>
<td>3.1</td>
<td>2.5</td>
<td>0.3</td>
<td>4.5</td>
<td>3.7</td>
<td>2.4</td>
<td>2.3</td>
<td>3.4</td>
<td>3.7</td>
</tr>
<tr>
<td>Other</td>
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<td>1.2</td>
<td>0.3</td>
<td>3.3</td>
<td>1.5</td>
<td>12.2</td>
<td>0.4</td>
<td>1.6</td>
<td>2.1</td>
</tr>
</tbody>
</table>
might be some justification for this administrative arrangement. Given that there is no control the role that CMC plays for West New Territories is not clear. It is located near a heavily populated area of Kowloon, from which it will draw at least some of its clientele. Although the ambulance services in Hong Kong are organized on a regional basis, with a broad similarity to the hospital regions, ambulances are generally instructed to deliver emergency cases to the nearest hospital even if this requires moving outside their normal operational limits. It is therefore unlikely that Caritas would receive many emergency ambulance cases from West New Territories, but rather will receive them from northwest Kowloon.

It is important to consider how patients are presenting in the different regions. As mentioned, a characteristic very much connected with the prevailing philosophy is that a majority of patients present as "emergency" rather than elective cases. In all major acute-general hospitals, the most important admitting department is AED. The work of the major AEDs is summarised in Table 3.12. With the exception of the university-linked Prince of Wales Hospital in Shatin, all hospitals admit in excess of 60% of their patients through AED. Of the large hospitals this can be as high as 72.8% (Kwong Wah - KWH). This emphasises that physical access to AED is important not only for real
emergencies but for most other cases as well.

However, AEDs are not all used in the same way. Attendances at AEDs are classified in Table 3.13. This shows in the case of trauma attendance variations which could reflect industrial activity, traffic variations and police preference (many assault cases for example are taken directly to hospital by the police and only the regional hospitals have custodial wards). The MHD is conscious of the amount of "inappropriate use" at AEDs which MHD defines as attendance by "those patients whose symptoms and conditions do not require urgent and immediate treatment as judged by the examining doctor". This too varies in the manner shown in Table 3.14 below.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Inappropriate attendance at Government AEDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMH</td>
<td>4.4</td>
</tr>
<tr>
<td>TSK</td>
<td>9.7</td>
</tr>
<tr>
<td>QEH</td>
<td>11.9</td>
</tr>
<tr>
<td>PMH</td>
<td>11.6</td>
</tr>
<tr>
<td>POWH</td>
<td>2.9</td>
</tr>
</tbody>
</table>

As Table 3.12 shows, there is variation in the balance of workload between traumatic and non-traumatic categories, and very great variation in the rates of admission amongst those presenting. The variation in rates of admission may reflect admissions policies more than the nature of the presenting ailments, and these policies can be influenced...
by bed availability (the academic staff of the medical faculty of the Chinese University have been able to insist that Prince of Wales Hospital uses no camp beds (SCMP, 10/11/86)). The final two columns demonstrate how attendance at AED and the admissions through AED vary between regions.

3.8 The distribution of hospitals within hospital regions

The hospital regions of Hong Kong are large, both in terms of population and physical size. As such, they may be comparable to the 4 health regions that serve London, but there is no additional lower tier of organization, such as the District Health Authorities that make up the regions in the United Kingdom. It has been argued that the notion that such large regions can be served by a single regional hospital is a product of a philosophy that can both accept very large hospitals and which places little importance on relationships with service areas. The low cost, "open access" philosophy gives legitimacy to Government claims as a service provider whilst placing the onus for presenting at hospital entirely on the public themselves. With such an outlook, the actual location of facilities has been given low priority.

Since the 1974 re-orientation towards the New Territories, it has been seen that modern hospital development has been
a very slow process and this is related in part to the size of projects undertaken. Given this slow development, there will remain areas both in the older urban districts and in the new towns in which physical access to hospitals, as for example by ambulance to AED, is extremely time consuming, if not very difficult. The average emergency ambulance transit time from scene of incident to AED in urban areas throughout Hong Kong remains high at 21.74 minutes. This does not include time needed to respond to the 999 call. The transit time in the New Territories, despite the greater distances involved is virtually the same (21.89 minutes). For non-emergency movements the average transit times are 46.27 and 50.09 minutes respectively. These are average times. Many calls will take less than this, the corollary of which is that some calls will take longer (source: communication from Ambulance Command).

3.9 Location details of hospitals in Hong Kong Island Region

The distribution of hospitals in the Hong Kong Island Region (Figure 3.1) seems to be determined by historical legacy with the majority of its hospitals dating to before the Pacific War. Private hospitals are within easy access of the CBD where private specialists have traditionally been located. Convalescent and long term hospitals are at (what were once at any rate) out-of-town sites. The oldest
hospitals in Hong Kong (Tung Wah and Nethersole) are in the oldest urban areas which date back to the 1870s. Hospitals seem to be clustered mainly in 3 areas (Figure 3.1):

- to the south and west of the original Central Business District;

- above and around Happy Valley;

- at out-of-town sites at Sandy Bay and Pok Fu Lam.

In general, compared with the other regions, Hong Kong Island has a generous provision of hospitals (Table 3.8). The problem is that the AED services and the necessary acute-general back up are not within easy physical access of some of the most rapidly growing districts. With the development of Chai Wan and Shau Kei Wan from the late 1950s onwards, problems of access to AED have increased. Traffic congestion along the north shore of the Island worsened in the 1970s, although with the completion of the Mass Transit Island Line and the Eastern Island Corridor (an urban motorway), travel times have since eased. Ambulance journey times to Queen Mary from Chai Wan are still, however, unacceptable.

In the 1960s, an attempt was made to lessen access problems by building the very small Tang Shui Kin Hospital. This has really acted as an additional AED for QMH. Patients are transferred once their condition has
"stabilised", the rationale being, in the words of one Deputy Director of MHD, that "once the patient's condition is stabilised, the time taken to transport the patient to Queen Mary becomes immaterial" (SCMP, 4/1/83 emphasis added). This has not been a satisfactory measure and has not negated the urgent need for a comprehensive AED service for the northeastern part of Hong Kong Island. This situation has presented a dilemma for the MHD. To improve access by building new facilities must necessarily involve increasing provision in an area which is comparatively well endowed.

3.10 Hospitals in the Kowloon regions

The distribution of hospital facilities in Kowloon region is given in Figure 3.2. The pattern comprises the following elements -

- a dominant concentration of acute-general and non-acute facilities in the Yau Ma Tei District;
- a group of less intensely used general hospitals/infirmaries in Wong Tai Sin District;
- private hospitals, predominantly in the low density residential areas in northern Kowloon City District (the Kowloon Tong area);
- two isolated major subvented acute-general hospitals in
the northwestern and northeastern parts of New Kowloon
(one of these, Caritas Medical Centre, as noted is
officially functioning as part of West New
Territories).

This pattern is unlikely to change. Given the priorities
of the 1974 White Paper, it is unlikely that any further
hospital development will take place, except the vague
possibility of the East Kowloon Hospital (Figure 3.2). The
concentration of acute services at the centre is
exacerbated by continual in situ expansion of Queen
Elizabeth. Provision in the northeast will increase with
the in situ redevelopment of United Christian to a 1400
bed facility (1995) but this still leaves much of the Wong
Tai Sin District more than a 3 Km radius from an AED
(Figure 3.2). At certain times of the day from the
northern part of Wong Tai Sin, it could take up to an hour
to get to AED at Queen Elizabeth or Kwong Wah by private
car, less perhaps by ambulance. Journey times to United
Christian might be shorter, but at present its AED is
unable to cope with additional work. With increasing size,
this hospital may have an expanded sphere of influence,
the possibility of which is discussed in Chapter 4. There
is also a possibility that UCH will suffer from the
greater access offered by the new East Harbour Crossing to
the people of Eastern District on Hong Kong Island in
3.11 Hospitals in the New Territories regions

The modern history of hospital development in the New Territories has been one of persistent failure to match the needs of a rapidly growing population. The Pok Oi hospital (1919) has only recently been upgraded to support an AED. Before 1972, this and the tiny Fanling Hospital were the only general hospitals north of Kowloon. Princess Margaret (1973) in Tsuen Wan was expected to act as a regional hospital for the whole New Territories and outlying islands (see Figure 3.3).

With the building of Prince of Wales, poor provision in New Territories East could be redressed with another large regional hospital. By the time this opened more than 300,000 people were living in Shatin. In the case of Tuen Mun New Town, a regional hospital, in theory, was not called for. The Tuen Mun Hospital (1989-90) represents a new venture in that it is the first purpose built Government "district hospital". It is becoming very difficult to see the difference between a "district" and "regional" facility. With this district hospital, the MHD has maintained its large facility obsession — building another hospital in excess of 1300 beds, which has taken a decade to construct and commission. When the Tuen Mun Hospital is opened (if staff can indeed be found), the population of Tuen Mun will be in excess of 300,000.
3.12 Case studies of hospital location decisions

The foregoing sections have suggested that in cases hospital locations may not be wholly appropriate to the changing nature of the Hong Kong urban area. With new hospital projects come the possibilities of new locations, even given the constraints of land availability already cited. Two case studies of recent hospital location decision-making are developed below to serve to demonstrate:

- how attempts were made to address the two problems of poor distribution and relative over-provision;
- the lack of resolve in Government decision-making and how the Government is subjected to particular influences;
- how ultimately, the prevailing hospital philosophy influences the final outcomes.

The case of a hospital for Eastern District (variously known as the Shau Kei Wan Hospital, the Eastern District Hospital and now as the Pamela Youde Hospital) is dealt with first, followed by the case of the relocation of Alice Ho Mui Ling Nethersole Hospital (henceforth Nethersole). Information for the Eastern District case study has been obtained from press accounts, published documents of the main pressure group involved (the Coalition for an Eastern District Hospital) and official
Government letters of response. In addition, for clarification of issues, a GP involved in the campaign and a community health worker from Chai Wan (acting on behalf of the coalition) were interviewed. For the Nethersole case study, information was obtained from MDAC minutes and from sources within the hospital management (see Introduction for discussion of methods).

3.13 Case study of a hospital for Eastern District

A desire to build a Government hospital in Shau Kei Wan was first expressed in the 1959 Annual Report of the MHD. This was intended as an infectious diseases hospital and was to be located in Shau Kei Wan because of the area's relative isolation. This hospital continued to receive mention in the MHD annual reports until 1968 long after the need for an infectious diseases hospital had passed (Coalition for an Eastern District Hospital campaign notes).

In 1973, the newly established MDAC suggested that the Shau Kei Wan site be used for a new mental hospital, but since the 1973 White Paper gave preference to hospitals in the New Towns, little came of this. The Government did, however, in 1978, offer a site to the Nethersole Hospital for it to relocate to Chai Wan, although the offer was quickly withdrawn.
In 1979, when the MDAC once again reviewed hospital services, they recommended a general hospital at Shau Kei Wan. The following year, the Government announced that a district hospital of 700 beds plus 550 beds for the mentally ill for the eastern part of the Island had been added to the Medical Development Programme (MDP) in Category C (see 3.4). At this stage this hospital was probably equal in priority to the East Kowloon Hospital, first publicly announced by the Government in 1973. There is little indication that the prospects for the Shau Kei Wan hospital were to have been any different to those for the East Kowloon Hospital which has remained dormant in the MDP for some 15 years. The prospects changed between 1980 and 1982 when there developed a major groundswell of public opinion in the eastern island area. This was to prove instrumental in influencing the Government. A combination of factors applied:

- what can be described as a chance factor — the involvement of particular personalities. Some of these were people working already in the area. In the case of one GP, noted for an activist stance in health care issues but not working in this area, this represented an important case for action;

- the involvement of two well established Christian groups (the Methodist Epworth Village which had run a community centre in this area since 1963, and the Star of the Sea Catholic Church);
- the organization of disparate interest groups (church groups, workers groups) into the "Coalition for an Eastern District Hospital";

- a clearly identifiable need that captured public interest;

- the establishment of the District Boards in 1980.

The last factor is the key one. Under the new District Board system, Shau Kei Wan and Chai Wan were grouped together to form Eastern Island District. This bolstered the Coalition. In addition, the elected District Board members represented areas which the public could perceive of as a hospital service area and the Board itself became very supportive of the campaign for hospital services. In the initial days of the District Boards, the Government was anxious to be seen to be responsive to them. From an analysis of the correspondence between the Coalition and the Government, the demands for a hospital were considered sufficiently serious by Government to be referred to levels higher than the MHD. The main official respondent to the demands of the Coalition, interestingly, was the Home Affairs Department (responsible for overseeing the District Boards) and not the Secretary for Health and Welfare or the Director of Medical and Health Services. There is other circumstantial evidence to suggest that in fact the impetus to upgrade the Shau Kei Wan Hospital (henceforth Eastern District Hospital) in the Medical
Development Programme in late 1983 came from outside the MHD.

However, as has been suggested, there is some difference between announcing intentions and executing them. A combination of circumstances succeeded in delaying the project. In January 1984, the Government had announced that construction work (after site preparation) would take place between 1987 and 1990 with opening planned for mid-1990 (SCMP, 17/1/84). This bold assessment of completion time was quite unrealistic, if not actually dishonest. In a press interview in 1988, a Government architect was quoted as saying that "a project this size would normally take 10 years to build, but we expect to complete it in eight" (SCMP 4/8/88).

In February 1984, a protest campaign by the occupants of part of the land - some 4000 residents in a Housing Authority cottage area - led to delays in handing over the site. The total site comprises 10 hectares, a considerable piece of land by Hong Kong standards. Much of this was unprepared hill side. The necessary site preparation work then took 4 years at a cost of around £50 million. Contracts for the hospital buildings were not signed until August 1988 after which the Government immediately encountered a contractual dispute which threatened to delay the project further still. The completion date of
the Eastern District Hospital (now renamed the Pamela Youde Hospital) is now given as "Christmas Eve 1996". (SCMP 4/8/88). According to press accounts, it will have 1750 beds incorporating a 650 bed unit for the mentally handicapped and retarded and will cost a total of £150 million excluding land preparation costs.

Partly in anticipation of delays and partly in response to continued pressure from the Coalition, in early 1983, the MHD announced stop-gap measures to improve AED services in the Eastern District (SCMP, 4/1/83). As a result, the Chai Wan Clinic (Figure 3.1) was converted to become a "casualty clearing centre" with a minor operating theatre and 24-hour cover. In addition, plans were announced for the redevelopment of the Ruttonjee Sanatorium (Figure 3.1) and its conversion from a TB hospital to an acute-general facility of 600 beds "to function as a district hospital for Eastern in the same way that the United Christian Hospital serves as a district hospital for Kwun Tong" (SCMP, 1/1/88). This comparison is not accurate as the opportunity to include an AED at Ruttonjee and close the small Tang Shui Kin Hospital (TSK) was not taken. Instead, the Government decided to press ahead with a renovation of TSK and to allow expansion at Tung Wah Eastern to provide additional beds to serve it.

Thus, a situation of comparatively generous provision that existed in the Hong Kong Island region in 1983, and to be
emphasised with the building of the Pamela Youde Hospital (Eastern District Hospital), was exacerbated by the interim measures needed whilst such a large cumbersome project is built. In addition, the MHD has gone ahead with major expansion at QMH throughout the 1980s. The reason given for this expansion to create another very large hospital on a limited site and in an unsuitable location, has been the need to upgrade clinical teaching facilities. It is alleged that this upgrading was demanded by the General Medical Council of the United Kingdom when inspecting the MBBS course at the University of Hong Kong in 1980. This is not necessarily a full picture. The necessary clinical facilities could have been provided at other hospitals in Hong Kong, for example at a redeveloped Ruttonjee or an expanded Tung Wah Eastern, helping to raise standards in these hospitals. This, however, would have conflicted with the MHD's philosophy of minimal education function. The degree to which it might also have affected the entrenched interests of some medical academics at HKU is, of course, pure conjecture. The Dean of the Medical Faculty at HKU has called for a teaching hospital exclusively for university use as opposed to "sharing" QMH (SCMP 11/9/87) with MHD uses.

In a sense, all these developments arise from initiatives or pressures external to the MHD. In the case of QMH, it is argued externally imposed standards were responsible; with the Ruttonjee, the initiative to redevelop came from
the Hong Kong Anti-Tuberculosis and Thoracic Association; the redevelopment of Tung Wah Eastern arose partly from the Tung Wah's desire to establish an ophthalmic unit; it is conceivable that Pamela Youde would probably never have been built had pressure groups not been so effective. Given the paucity of clear hospital policy demonstrated in Chapter 2, the impact of such initiatives should not be surprising. Policy and philosophy are not the same thing. In the absence of policy, hospital philosophy provides the only guidelines for development.

3.14 Case study of a relocation of hospital facilities

The case of the Nethersole Hospital is another example of external initiative confronting the MHD on Hong Kong Island. This involves an unusual situation in Hong Kong of a hospital wanting to relocate, and through it exposes something of the mechanisms that operate in hospital location in Hong Kong. The Nethersole Hospital, has for one hundred years been located in the Mid-Levels of north western Hong Kong Island (See Figure 3.1). In the 1970s, it became apparent to the management of the Nethersole that its facilities had become inadequate for the continually increasing utilization (Paterson, 1987, op.cit.). The hospital had increased to about 380 beds, which although too small to be very economic, was still more than the buildings could adequately house. The physical fabric, in parts dating back to the 1930s,
required urgent and drastic rebuilding. The site was too small for a major new building. Redevelopment would have had to be piecemeal making use of small plots within the site. Mid-Levels had serious geotechnical problems and throughout much of the 1970s, a ban on all new building in the area was imposed.

There was also a realization that the hospital's location, in an area of declining population, and close to other facilities, had become obsolete. Proposals were made by the hospital management to the hospital's board to move to a new site. This met with considerable opposition from board members anxious to preserve the historical links with the area. To a large degree, these links were tenuous. The hospital had no definition of its service area and patients came from many parts of Hong Kong.

In 1978, the hospital management approached MHD for support for a move. MHD suggested that a site in Chai Wan would be available (see 3.13 and Figure 3.6). The hospital board commissioned a feasibility study of the Chai Wan site, but the site was then withdrawn by the MHD who suggested instead a site in East Kowloon on the border of Kwun Tong. This had been reserved for the East Kowloon Hospital that the Government, in 1973, had announced it would build. The offer of the East Kowloon site stimulated a new proposal to combine a relocation of the Nethersole
Figure 3.8 Sites considered in the relocation of Nethersole Hospital
with a reprovisioning of the United Christian Hospital (UCH) in Kwun Tong, with which the Nethersole has had close links. The new hospital would share ancilliary services with a reprovisioned UCH, achieving economies of scale and greater provision but avoiding the pitfalls of a single very large hospital. Clinical responsibilities would be divided between the hospitals and management functions could be combined. Initial surveys were embarked on, but once again these faltered when suddenly, the MHD withdrew the East Kowloon site. Somewhat disheartened, the hospital management returned to the initial idea of redeveloping in situ. Plans and estimates were prepared but these were then rejected by the MHD who now made it clear that no money would be available for any in situ development.

So once again, the hospital embarked on a search for a site. An application was made for a site earmarked for a private hospital in the new town of Shatin. This was refused but the MHD now suggested four new sites (Figure 3.8): another site in Shatin; Braemar Hill on HK Island; a site on the Lung Cheung Road in North Kowloon; and one at Sheung Shui in the eastern New Territories. Each of these sites had major disadvantages. The Braemar Hill site was surrounded by high class housing and was unprepared hillside. The Lung Cheung Road site was physically distant from centres of population and too near Caritas Medical Centre. The Sheung Shui site was on military land and not
to be available until 1991 at the earliest. Only the Sheung Shui site, in a fast growing part of the New Territories and far from hospitals, seemed to reflect the priorities of the 1974 White Paper. The impression given was that the MHD was simply going through what amounts to quite a substantial bank of land that it has some control over. Having had second thoughts over offering the prime sites, such as at Chai Wan and East Kowloon, it seemed as if the Nethersole was now being presented with a lower tier of sites. Clearly nothing would progress until the MHD treated the Nethersole relocation with some urgency and seriousness.

In the event, the pressure for this came from within the MHD. With the establishment of the new East New Territories region, the incoming Regional Director pressed for a rapid development of facilities in the north of this region which, as has been seen is the most poorly provided for. Towards the end of 1986, the MHD agreed to a site in Tai Po New Town for a new Nethersole. Furthermore, the new Nethersole was to be given a clear function to act as the acute-general district hospital with AED for the Tai Po District and areas to the north.
It has already been noted that, as service areas, the hospital regions have highly permeable boundaries. Any assessment of regional provision and utilization is complicated by the movements of people over these boundaries. There is, however, one health care service in Hong Kong that adheres strictly to service areas and for which it is justifiable to assume that the patients normally reside within the service area boundaries. This is the Community Nursing Service (CNS) which (like "district" or "home" nursing elsewhere) visits the patients at home to perform nursing procedures, which would otherwise have to be done in a hospital or other central facility. It will be examined here because its coverage of the population can be accurately assessed and also because this kind of service should have a profound influence on the effectiveness of hospitals. In many ways, as this account shows, community nursing sits uneasily within the prevailing philosophy and that there is a great difference between the way it is operated by MHD and by subvented agencies.

The concept of Community Nursing is an old one. Its late adoption in Hong Kong is partly a reflection of unimaginative medical policy and of concerns that specific Hong Kong problems, such as the overcrowded and inadequate
housing, might make this type of nursing impractical. It was also feared that the difficulty of moving around the congested urban area would make such care uneconomical; that left unsupervised between visits, people would mix western and traditional therapies; and that the very poorly developed systems of referral would fail to make effective use of the service (CNS, 1973).

Today, despite these misgivings, the service is well established. It is operated by 8 agencies comprising the MHD and 7 subvented organizations, some of whom pioneered the service and developed it over a 10 year period before the Government agreed to subvent it in 1977. Each agency is given responsibility for a service area or a number of service areas centred on Community Nursing bases. This is the only example of a health care service in Hong Kong that is administered on a strict service area basis. Nurses do not operate outside their service area.

In 1985-6, Community Nursing territory-wide dealt with 12,305 patients over 211,895 visits. This represents a slight decrease in patients over 1984-5 but an increase in visits, possibly reflecting the increasingly chronic nature of the cases. With the falling birth rate and the improvement of the Government Maternal and Child Health Service, the demand on maternity CNS has stabilised. The ageing of the population on the other hand, has emphasised the need for long term therapy for victims of strokes,
ischaemic heart disease, diabetes and other chronic ailments such as Parkinson's disease and arthritis. Between 1979 and 1985, the proportion of patients aged 20-39 declined from 45.5% to 41.7% whilst those aged 65 and over increased from 31.4% to 40.7%. Only one third of CNS patients are male but this is greater than in 1979 when the proportion was just over a quarter.

Overall demands on the service increased from 1977 to 1983 after which there has been a slight fall-off in numbers. This has been suggested as a possible indication of supply meeting demand (MDAC papers, 1984), a point disputed below. In 1981, MDAC papers projected a caseload of 34,992 with 776,001 visits for 1983-4 with 703 nurses compared with the 181 nurses who were actually employed in that year dealing with just over a third of the cases predicted (MDAC minutes, 1981). What exactly the MHD were thinking of when they came up with this estimate is difficult to comprehend, but clearly they misinterpreted the situation and failed to anticipate obstacles to the services' rapid uptake. It will be argued that these obstacles are associated with the prevailing hospital philosophy.

It would seem that different agencies have different perspectives on the purposes of CNS. In its official annual report its objectives are listed as:

- care and treatment for discharged hospital patients;
- education and to motivate patients and their families to participate in the treatment process in the home (HK Govt, 1986b)

It is strange that not included in the list is the specific objective of increasing bed availability and utilization in hospitals. In Hong Kong, Community Nursing has always been intended as a service for hospitals. The fee charged is the equivalent of the Government daily hospital charge (remittable on the same grounds as hospital fees) suggesting that it is an alternative to inpatient care. Hospitals are the main source of referral to the service accounting for 83.9% of the total caseload in 1985-6. The other referrals come from sources shown in Table 3.15 below.

Table 3.15  Referral sources for all CNS patients, 1985-6

<table>
<thead>
<tr>
<th>Source: HK Govt, 1986b op.cit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
</tr>
<tr>
<td>Government hospitals     22.2</td>
</tr>
<tr>
<td>Subvented hospitals      60.7</td>
</tr>
<tr>
<td>Private hospitals        1.0</td>
</tr>
<tr>
<td>Outpatient clinics &amp; AEDs 10.2</td>
</tr>
<tr>
<td>Private GPs              3.2</td>
</tr>
<tr>
<td>CNS centre transfers     2.3</td>
</tr>
<tr>
<td>Day hospitals            0.4</td>
</tr>
<tr>
<td>100.0 %</td>
</tr>
</tbody>
</table>

With the types of hospital patients targeted for CNS being selected surgical patients discharged early after operations; medical cases of a chronic nature; and maternity cases (CNS, op.cit.) and the top 5
diagnostic groups treated being obstetric, circulatory, trauma, endocrine and nervous system diseases (H.K. Govt., 1986b op. cit.) CNS has a clear role to play in speeding the discharge of patients from hospital. Much of the early enthusiasm for CNS was based on this notion. The idea that early discharge might free beds in hospitals was cited as reason to suggest that in the case of the United Christian Hospital, the service could double effective bed availability (CNS, op. cit.). This optimistic forecast was based on an unrealised ideal that the community nurse might be part of a team within the community, involving volunteers and "good neighbours". Benefits have nevertheless been felt to be substantial, but there seems to have been no scientific evaluation of the effective number of beds that Community Nursing is substituting.

It seems that the MHD deliberately plays down this role. The annual CNS report (H.K. Govt., 1986b, op. cit.) seems to regard only those patients referred to CNS by hospitals and then readmitted to hospitals after a period of care with CNS, as indicants of bed saving (ibid, p.3). This group amounted to 2620 in 1985-6. Whether this is indeed evidence of bed saving is debateable. However, there are many other examples of bed saving by CNS that the MHD seems to ignore. Without CNS, discharge of many obstetric cases within 24 hours of delivery would not be possible. It is significant too that in 1986, 20.9% patients were classed as "bedridden", 9.5% as mobile only in a wheel
chair and 41.0% as requiring some form of walking aid. If care was not available in the home, one has to assume that many of these patients would occupy space at care-and-attention homes (interestingly outside the remit of MHD and therefore not its responsibility) or in hospitals. Of CNS patients in 1985-6, 4.5% lived alone.

There is a case to argue that the MHD has been indifferent to the idea of Community Nursing. In Table 3.15 it can be seen that Government hospitals contribute only 22.2% of the referrals to the service. Suggestions of Government hospital disinterest can be seen in a comparison of workloads of the various agencies and the variation in impact of CNS between the agencies, and therefore spatially, across Hong Kong. Table 3.16 shows a clear difference in productivity between agencies with the MHD CNS performing poorly in comparison to some of the others, in terms of patients served, use of nurses and provision for the population at large.

Figure 3.9 shows the spatial variation in impact of CNS services based on the crude measure of patients served per thousand population. The picture is a confused one. Impact seems low in two areas that are clearly deprived of easy access to acute-general facilities, Eastern and Wong Tai Sin. It is also low in three districts where physical access to acute-general hospitals is relatively easy - Mongkok, Yau Ma Tei and the combined districts of Tsuen
Table 3.16 Variations in the work of the Community Nursing agencies by District Board Districts, 1986

(Source: H.K. Govt., 1986b; H.K. Govt., 1987b)

<table>
<thead>
<tr>
<th>District</th>
<th>Population</th>
<th>Agency</th>
<th>Patients /1000 pop</th>
<th>Patients nurse</th>
<th>Nurses nurse</th>
<th>Visits /nurse /day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kwun Tong</td>
<td>678 265</td>
<td>UCH</td>
<td>4168</td>
<td>6.2</td>
<td>31.7</td>
<td>21 396 6.9</td>
</tr>
<tr>
<td>Wong Tai Sin</td>
<td>239 499</td>
<td>OLMH</td>
<td>867</td>
<td>2.0</td>
<td>13.1</td>
<td>32786 4.3</td>
</tr>
<tr>
<td>Kowloon City</td>
<td>423 976</td>
<td>YSSC/TW</td>
<td>500</td>
<td>1.2</td>
<td>13.6</td>
<td>31 174 3.9</td>
</tr>
<tr>
<td>Shum Shui Po</td>
<td>424 659</td>
<td>CMC</td>
<td>1022</td>
<td>2.4</td>
<td>14.0</td>
<td>30 333 5.1</td>
</tr>
<tr>
<td>Hong Kok</td>
<td>202 412</td>
<td>CMC</td>
<td>289</td>
<td>1.4</td>
<td>4.0</td>
<td>50 603 5.4</td>
</tr>
<tr>
<td>Sai Kung</td>
<td>45 276</td>
<td>RM</td>
<td>163</td>
<td>3.6</td>
<td>2.6</td>
<td>17 413 2.5</td>
</tr>
<tr>
<td>Yau Ma Tei</td>
<td>142 870</td>
<td>TV</td>
<td>229</td>
<td>1.6</td>
<td>6.9</td>
<td>20 705 2.5</td>
</tr>
<tr>
<td>Cen &amp; West</td>
<td>251 846</td>
<td>MHD/TW</td>
<td>689</td>
<td>2.7</td>
<td>13.0</td>
<td>19 372 2.9</td>
</tr>
<tr>
<td>Southern</td>
<td>237 888</td>
<td>MHD/NH</td>
<td>708</td>
<td>3.0</td>
<td>13.5</td>
<td>17 621 2.8</td>
</tr>
<tr>
<td>Eastern</td>
<td>490 181</td>
<td>NH</td>
<td>880</td>
<td>1.9</td>
<td>13.4</td>
<td>36 580 4.7</td>
</tr>
<tr>
<td>Wan Chai</td>
<td>195 944</td>
<td>NH</td>
<td>616</td>
<td>4.2</td>
<td>10.7</td>
<td>15 428 6.1</td>
</tr>
<tr>
<td>Tsuen Wan</td>
<td>654 150</td>
<td>MHD</td>
<td>945</td>
<td>1.4</td>
<td>19.1</td>
<td>34 248 2.6</td>
</tr>
<tr>
<td>Tai Po</td>
<td>284 529</td>
<td>MHD</td>
<td>225</td>
<td>0.8</td>
<td>6.5</td>
<td>43 710 2.9</td>
</tr>
</tbody>
</table>

Agencies: UCH - United Christian Hosp
OLMH - Our Lady of Maryknoll
YSSC - Yang Social Service Centre
TW - Tung Wah Group
CMC - Caritas Medical Centre
RM - Rennie's Mill Clinic
NH - Nethersole Hospital
MHD - Medical & Health Dept

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Figure 3.9  Varying impact of Community Nursing Services in the older urban areas
Wan and Kwai Chung & Tsing Yi. In Wanchai and Kwun Tong, however, where the impact appears to be relatively high, there are general hospital facilities.

Is it possible that differential impact is a response to differential need? Whilst in the absence of satisfactory information about variations in health status this must remain a possibility. But there may also be connections with varying approaches to CNS by the different agencies. The approach adopted may be dependent on the attitudes of the agency involved and/or its ability to increase its impact.

Utilization of the CNS service depends partly on the ability of agencies to attract referrals and also on the amount of nurse travel involved. This is influenced by the distance of patients from the CNS base and by the location and number of bases (this might account for lower impact in more rural areas such as Sai Kung and elsewhere in the New Territories). Referral systems in Hong Kong are weak and there is a tendency for referrals to stay within organizations. A small hospital such as Our Lady of Maryknoll may not have that many patients to refer to its CNS agency. While it is responsible for all CNS cases living in the Wong Tai Sin district, other hospitals may be less inclined to refer patients to the service. A contrasting situation is found in Kwun Tong where a greatly overstretched hospital, without access to many
convalescent beds and desperate to free beds within the hospital, has enough CNS referrals to keep its own agency very busy. This has been aided by a deliberate policy of providing a very dense network of bases leading to nursing workloads that are twice those of the MHD's community nurses. Even with this very comprehensive service, as Table 4.10 shows, referrals in from other hospitals form a small part of the workload.

Government centres are far less concentrated. Their nurses spend far greater time travelling and averaged only 3.1 visits per day in 1985-6, an increase over previous years. There is no specific link between the MHD's CNS and any particular hospital and so there is little possibility of any fruitful relationship between doctors and nurses developing. The MHD CNS seems to concentrate on the very elderly with patients over 60 years of age comprising 53.9% compared with 26.9% for UCH CNS. Over half of UCH CNS cases (58%) are obstetric. These figures might go some way to explaining the results of a survey into case cancellation given in Table 3.16. Case cancellation occurs when CNS visits stop before the course of treatment has ended.

Even allowing for the greater number of elderly patients dealt with by MHD CNS, some inferences can be made. The data suggests that Government has greater access to other hospital beds, old age homes and care-and-attention home
Table 3.17  Reasons for case cancellation, UCH and MHD  
CNS agencies, 1985-6  

Source: HK Govt, 1986b

<table>
<thead>
<tr>
<th>Reason for cancellation</th>
<th>MHD</th>
<th>UCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient live outside service area</td>
<td>47</td>
<td>11</td>
</tr>
<tr>
<td>Patient died</td>
<td>33</td>
<td>2</td>
</tr>
<tr>
<td>Type of case not suitable</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Patient's condition too serious</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Patient goes to old age home</td>
<td>34</td>
<td>4</td>
</tr>
<tr>
<td>Patient goes to care &amp; att home</td>
<td>65</td>
<td>0</td>
</tr>
<tr>
<td>Patient goes to China</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Patient goes to other medical inst</td>
<td>101</td>
<td>9</td>
</tr>
<tr>
<td>Patient/relative refuses because:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- financial reasons</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>- family objections</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>- they think CNS can't help</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Patient not accessible</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Other reasons</td>
<td>53</td>
<td>29</td>
</tr>
<tr>
<td>Total cancellations</td>
<td>398</td>
<td>63</td>
</tr>
<tr>
<td>Cancellations as % total cases interviewed</td>
<td>14.1%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>
places than UCH. It would also seem that doctors referring
to MHD CNS are making more errors with address and
clinical judgment, at least in the eyes of the nurses,
than doctors referring to UCH CNS. The attitudes of the
nurses, may be a crucial factor. While one cannot draw
hard conclusions from this survey alone, the high rate of
patient/relative refusals does seem to be strange.

There is a strong feeling in some of the agencies that MHD
is not really interested in CNS and does not want to see
its expansion. It is highly significant that CNS was not
included in the remit to the 1985 Review of hospital
services although the Review was largely concerned with
making hospital services more effective. There was
therefore no mention of CNS in the final recommendations
(HK Govt, 1986a). The idea of community nursing is simply
not in harmony with prevailing hospital philosophy.

While it is likely to be a cost effective approach
(although no serious study has been done of this), it is
seen as an additional expense. Community nursing steps
beyond the bounds of technical intervention. It involves
too many other things - health education, chatting,
organizing home-help - and by expensive medical
professionals too. These are not the traditional concerns
of the Medical and Health Department but those of the
Social Welfare Department. In terms of perspective for
overall evaluation CNS smacks of long term interest in patients, and inevitably, with geriatric, many psychiatric patients or those suffering from strokes, this means lifetime involvement.

In terms of the managerial style aspect of philosophy, CNS represents a devolution of clinical responsibility. It demands a high level of initiative on the part of the nurse. One problem for the nurses in the MHD CNS agency has been their subjection to regulations. For instance, they cannot remit or reduce the fees charged. Only a Government Social Worker can do this. The prevailing philosophy as exemplified in Government hospitals has encouraged very strict division of labour including very clear professional boundaries, closely guarded by professional unions. Community nurses take on the work that might otherwise be done by doctors in hospitals. Partly as a result of this, there is a greater concern over legal liability. This is thought to be a reason for some doctors in Government not referring cases to CNS. It may also mean that as far as the MHD is concerned, CNS does not substitute for hospital beds. In the final analysis, the greatest problem philosophically, may well be the fact that, by its very nature, community nursing involves service areas and dealing with people in their homes, their environments and their communities and not within the walls of the technological institution.
3.16 Conclusion

Whilst avoiding a deterministic cause-effect approach, this chapter has shown how aspects of prevailing hospital philosophy can be associated with the location, distribution and operation of services over space. Whilst the constraints of the politico-economic system and the physical constraints of land availability are very real in Hong Kong, the case studies have shown that there is scope for some choice and that initiatives outside the bureaucracy can have impact.

This is also demonstrated in the very variable approach to community nursing. In this, the United Christian Hospital CNS agency demonstrates the greatest difference to the MHD "norm". This different approach has been possible within the constraints imposed by the bureaucracy. Community Nursing is just one aspect of the alternative approach of the United Christian Medical Service (UCMS). Chapter 4 examines the other components of UCMS in detail assessing the extent to which they too can operate at variance to prevailing modes and the extent to which UCMS has succeeded in fulfilling its grand intentions as stated in Chapter 1.
Chapter 4 - Kwun Tong and the United Christian Medical Service - attempts at an alternative approach

Chapter outline

Chapter 3 has shown how aspects of prevailing philosophy have been associated with hospital developments over space. It has been seen that despite constraints it may still be possible for variation to exist and some scope for choices in service approach to be made.

In Chapter 4, this possibility is examined in the context of the Kwun Tong area and the approach of the United Christian Medical Service and the United Christian Hospital which as seen in Chapter 1, have proclaimed their own philosophy of hospital care.

The chapter starts by recapping the basic tenets of the UCMS approach, first proposed during the planning stages for building the United Christian Hospital. The planning history of this project is described in detail, providing a further case study of location decision-making but one where a clear idea of objectives can be linked to the final choice of location and site.

Given the apparent importance of "community health" ideas and the service area, Kwun Tong as a City District is described showing how rapidly urban areas of Hong Kong grow and change. The idea of Kwun Tong being a "spatial community" is challenged. In this complex urban setting, medical services of a great variety operate with complex relationships. Although the only acute-general hospital in the area, UCH has little monopoly over health care services and so inevitably can only have a partial relationship with its self-defined service area.

UCH's heavy utilization by the people of Kwun Tong is examined. Characteristics of this emphasise the desirability of effecting some of the ideas of community health and intersectoral collaboration. The attempts of UCMS and UCH in "reaching out" to the Kwun Tong area - the "centrifugal" intention are also critically examined. Community Nursing (already mentioned in Chapter 3) is given further attention as it the operation of the Kwun Tong Community Health Project. All aspects of UCMS outreach are classified in a simple framework to assess their impact on the service area. A conclusion is reached of UCMS effective status in terms of the adaptation of Rifkin's classification discussed in Chapter 1.
4.1 The UCMS approach

The United Christian Medical Service philosophy (Chapter 1) has emphasised a broad basis to health and the need for people to be involved in health care themselves. The importance of openness and access in promoting communication and learning are stressed. There are ideals to work towards, involving improvements to life as opposed to simply "technical" improvements to 'wellness' status. Above all, there is an outward looking approach to the surrounding service area (a "centrifugal" outlook).

In pursuit of some of these intentions, UCH has adopted some fairly simple measures regarded as innovations in Hong Kong, but which may be commonplace elsewhere. For instance, at UCH, notions of "service" and "public involvement" have been interpreted by recruiting large numbers of volunteers. As a non-Government agency, it finds it easier to recruit volunteers and appears not to encounter resistance from its less-unionised workforce. Attempts by the hospital to involve the community are also seen in the annual open days the hospital holds, attended by thousands of visitors.

An alteration in outlook may involve fairly minor managerial adjustments as has been the case in the relatively mundane, but important matter of more liberal patient visiting hours. Sometimes, as in the case of
training and supervising volunteers or the chaplaincy support programme, access to alternative funding is necessary. Sometimes, all that has been introduced is a different attitude (as in certain innovations in the syllabus in the nursing training school). When the new Chinese University Medical Faculty was without hospital facilities (due to delays on the Prince of Wales teaching hospital in 1985), UCH was the only hospital prepared to offer substantial access to its facilities and patients. Firm teaching links established then have continued after the completion of Prince of Wales and have brought great benefits to UCH, normally only gained in Hong Kong by teaching hospitals. One final example of open attitudes is seen in the readiness of UCH to establish working links with a number of hospitals in China both in training and in assistance with the design of facilities.

To go beyond this level is more difficult. In terms of philosophy, the greatest difficulties will arise in altering the role the hospital plays. In the case of UCH, this centres on the way the hospital relates to the service area and the effectiveness of intersectoral collaboration. The above facets of openness and communication with the public are symptomatic of a looking-out and will contribute to a more centrifugal relationship, but in themselves, they are not enough.
4.2 The project to build a "United Christian" hospital

It is useful first to consider the origins of the United Christian Hospital. Information on this has been obtained from minutes of meetings (see note on methods in Introduction). The history of this hospital and the final decision to locate it in Kwun Tong, can be compared to the locational case studies in Chapter 3. It is yet another example of how the impetus for change or development came from outside the MHD and once again exposes the confusion of Government policy. The UCH story shows too, how, in an environment of uncertain Government direction, ideas can develop and become guiding influences and how, despite the prevailing hospital philosophy, there is still some potential for innovation by non-Government agencies.

The seeds of a joint hospital venture amongst Protestant groups in Hong Kong were sown in 1958, when large numbers of China refugees were creating strains for medical services. Hong Kong's status as a refugee destination made it eligible for small amounts of US aid for specific projects and in the late 1950s, Catholic interests were successful in persuading the US Government to finance the building of Our Lady of Maryknoll Hospital in Wong Tai Sin. It was expected that the US Government would feel obliged to support a Protestant hospital as well.

The Hong Kong branch of the US-based Church World Service called an exploratory meeting for a "Union Christian
Hospital" in 1958, after having had informal discussions with the Director of MHD. The Director had expressed a desire for "an institution for mental defectives to care for about 400 persons if possible to be operated by some Christian group which would be motivated by Christian love and concern". He had also voiced "a strong preference for a centralization of hospitals in the Kowloon area with patients being brought in from clinics scattered throughout the New Territories" (UCH minutes, 1958). Little came of the original meeting. It would seem that a hospital of only 60 beds was envisaged and this was not likely to interest the Government.

By 1962, the idea had revived. The MHD had projected a shortfall of 1000 general hospital beds by 1973 and was looking for ways of providing those beds. A number of Protestant groups considered building their own small hospitals. The 1958 committee reformed and developed the idea of a single central Protestant hospital to which church clinics throughout Kowloon could send their patients. This would avoid the duplication and diseconomies of several small hospitals. At the time it was thought that for an acute general hospital, 500 beds would be economic.

The Protestant groups were by no means unified. Three groups went ahead with plans of their own in the 1960s.
The German Lutherans built the (then rural) Fanling Hospital which they later handed over to the MHD. Another group built the Evangel Hospital, a small private concern, whilst the US Southern Baptists built Baptist Hospital, a much larger private hospital. In addition, the Anglican Bishop of Hong Kong pursued his own unsuccessful campaign for a 200-bed children's hospital.

Even in the early 1960s, there was considerable debate in church circles over involvement in hospital care. The US Presbyterians, important potential supporters of the Hong Kong project, queried whether it would not be better "to work through public health measures and outpatient clinics seeking to prevent illness and disease rather than being tied down to a large institution on a long term basis" (UCH minutes, 1962). In October 1963, their Medical Secretary visited Hong Kong emphasising the "revolt against institutionalism" being experienced in many parts of the world –

"institutions operated by the Christian church are being seriously questioned. In some areas, hospitals are being closed or turned over to other agencies. In some cases, Christian hospitals are not able to command the financial support from the churches which is needed to maintain a satisfactory quality of service. Now a request comes from Hong Kong wanting to build a new Christian hospital, and not only that, a rather large one. If such a proposal is to get a favourable response, a strong case will have to be made showing the feasibility....." (UCH minutes, 1963).

It was indicated that in the eyes of the US church, co-operation with an existing church hospital (such as the
Nethersole) would significantly strengthen the new hospital's case. At the same time, it was also clear that any successful Protestant hospital would have to secure Government funding.

As to the site of this hospital, there were, apparently, a number of choices. The MHD had intimated that Tsuen Wan (Figure 4.1) would be its most favoured site for a hospital. Many on the Committee, however, felt that East Kowloon, had a greater need and that a site here should be pursued. Discussion was pre-empted when in January 1963, the MHD, having suggested a Tsuen Wan hospital, tentatively earmarked a site at the end of Waterloo Rd in Kowloon for a United Protestant Hospital. The Director of MHD gave his strong support to such a project in the budget debate. However, by August 1963, the MHD had changed its mind offering instead a Kwun Tong (East Kowloon) site or "2 or 3 possible sites in North Kowloon". By September 1963, the MHD narrowed down the options to two sites on the Lung Cheung Road in North Kowloon. In April 1964, one of these sites, at Tai Wo Ping, was assigned to the project.

The project now became known as the United Christian Hospital, and between 1964 and 1968 a major attempt was made to secure capital funding from overseas, particularly from the USA, West Germany and the Netherlands. In December 1968, the EZE,(the West German Protestant
Locations considered for a "United Christian" hospital, 1962-1969

Figure 4.1
Development Agency) finally agreed to a large capital grant. Having secured major financial support, the Committee were then freed from having to satisfy small individual churches, and could then question the very basis to the project - a central hospital serving Christian clinics throughout Kowloon. There was, in fact, little evidence that Christian clinics would necessarily use the hospital in this way, and that given the health care behaviour of Hong Kong people, it was likely that patients would present in much the same way as they would at any other hospital. It therefore made sense for the hospital to be in a location where it provided the "maximum benefit". The Tai Wo Ping site on the Lung Cheung Road was physically difficult to get to. Furthermore, the Caritas Medical Centre (a large Government-subvented general hospital) was being built nearby.

It was at this stage that the Committee became interested in the ideas of "community health" and "community hospitals" being expressed at that time and given impetus by the formation in 1967 of the Christian Medical Commission (an agency of the World Council of Churches). Dissatisfaction over the Tai Wo Ping site grew and attention was turned again to Kwun Tong in East Kowloon where a hospital serving a specific community could be envisaged. The minutes of a meeting in December 1968 noted that whilst in 1963, "factors favoured the Lung Cheung Rd site", the population of Kwun Tong was 351,000 and was
expected to reach 500,000 by 1970. No general hospital facilities or AED had been built in Kwun Tong, nor were any planned.

This was a major change in stance from providing for a selected group to providing, without qualification, to a defined service area. An approach was made to MHD for a Kwun Tong site. MHD responded quickly, once again demonstrating the real extent of its land bank by offering a choice of 4 sites (Figure 4.2 - sites A, B, C, D). The Committee expressed interest in an additional site (E) earmarked for two secondary schools. The MHD declined to advance a case for this with the Town Planning Board. The Committee chose site A (Plate 1) in February 1969 largely on the grounds of technical suitability and size coupled with the site's excellent access to the rest of Kwun Tong (this can be seen in Plates 2 to 5). The German donor approved the change of location and the Government and major local donors were approached for funding. Once the site was finalised, the project progressed very rapidly indeed. The hospital opened in November 1973 and was fully operational by 1975. Of the other sites only sites D and E were considered large enough and site D was quite inaccessible to existing roads. It is interesting to note that by 1989 all sites had been utilised with the exception of site D. Site B was allocated to a church-based clinic and children's home in 1970 and site C was reassigned to the Housing Authority in the 1980s.
Figure 4.2  Sites within Kwun Tong considered for United Christian Hospital, 1968-1969
Plate 1
United Christian Hospital, looking north towards Fei Ngo Shan
Sau Mau Ping Estate can be seen to the left; to the right are Home Ownership blocks (built on Site C); in the far distance is Lam Tin Estate; in the middle distance, the old Tsui Ping Rd H-blocks and redevelopment.
Plate 3  View from UCH looking east south east

Lower Sau Mu Ping Estate in the foreground overlooking vacant plot reserved for UCH extension. Upper Sau Mau Ping in the background. In the early 1970s, the Sau Mau Ping Estates housed 130,000.
Overlooking vacant plot in foreground reserved for secondary school and additional vacant land at present occupied by squatters and scrap merchants. The tall building in the foreground is a Divisional Police Station. The Lok Wah Tsuen Estate is on the hill on the right. Behind the police station are the private residences of Crocodile Hill. In the far distance can be seen Victoria Harbour and Hong Kong Island.
Plate 5  View from UCH looking north

Overlooking the UCH Nurses' residences towards the 1980s-built Shun Tin and Shun On Estates. Fei Ngo Shan towers in the distance.
4.3 The Geography of the Kwun Tong Service Area

As has been seen, formal definitions of service areas, other than for hospital regions, do not exist in Hong Kong. United Christian Hospital has taken it on itself to define a service area, although it has no real powers to make its boundaries impermeable. There were several reasons for doing this:

a. the part of New Kowloon in which it is located is particularly poorly provided for in terms of hospital care and pressure on facilities is inevitably high. The catchment has, by necessity, to be limited;

b. some division of responsibility was thought to be needed over accident and emergency cases, especially those brought to the hospital by ambulance;

c. most importantly, since the hospital was established with the aim of promoting Community Health ideas, an interactive service area is essential to the hospital's philosophy. Indeed, the desire to introduce these ideas to Hong Kong was sufficiently great as to influence the planners to locate the hospital in Kwun Tong as this seemed to be a readily identifiable unit.

Kwun Tong is the urban area to the east of Kai Tak Airport in the easternmost part of New Kowloon (Figure 3.2). The area can readily be identified as a distinct physical entity (Figure 4.3). It is bordered to the north by a
range of hills (up to 250m), now extensively quarried for granite; to the south and east by the coastline which has been extended through reclamation; and to the west by the Clear Water Bay Road at the base of Fei Ngo Shan (603m) (Plate 5). This is the area now covered by the Kwun Tong District Board, whose 12 constituencies elect members to the District Board.

Before 1954, there were only 5 fishing and farming villages in the area, the most notable of which were the villages at Lei Yue Mun (the "Carp Gate" to Victoria Harbour). It was a tranquil rural scene with neatly terraced fields on the rotting red granite. In the Qing Dynasty, there had been some army barracks, but there was never any dense inhabitation due to the hilly nature of the land and the distance to the established population centres around the Harbour. The Kwun Tong shoreline did not figure prominently in Hong Kong's pre-War development as a port. In 1947, Shell built an oil storage depot on reclaimed land and the Government started dumping garbage which formed the basis for new reclamation works.
Figure 4.3  Kwun Tong - physical features
In the 1986 By-census, the population of Kwun Tong was estimated at 678,265 (HK Govt., 1987a). The growth of the population is shown in Figures 4.4.1 and 4.4.2. Over the past 35 years, the area has been transformed beyond recognition with substantial engineering alterations to the physical landscape in the form of site levelling and sea reclamation (see Figure 4.3). Development of the area was commissioned in 1954 by the Government partly as a decentralization project to relieve more crowded areas of Kowloon where space for new development was unavailable and where building height regulations in the airport flight path restricted development potential. Kwun Tong's development was also a response to demands for industrial land. With the influxes of migrants from China in the late 1940s and early 1950s, and the ending of the traditional China entrepot trade with the UN embargo on China trade brought on by the Korean War, the Hong Kong Government was anxious to promote industrialization. To date, over 100 ha of industrial land have been reclaimed in Kwun Tong. The District has in excess of 3000 industrial establishments with garment manufacture the leading sector. Electronics and metal working are also important. Some 70,000 workers are employed in manufacturing within Kwun Tong.

Leeming (1973) has suggested Kwun Tong represents "a radical departure in Hong Kong public life" because there was a comprehensive plan for development unlike the
Figure 4.4.1 Kwun Tong population growth, 1951-1991

Figure 4.4.2 Kwun Tong population structure, 1986
previous laissez-faire Hong Kong development experience. In comparison to the comprehensive planning of New Towns built in the 1970s and 1980s, such as Junk Bay now being built just to the north of Kwun Tong, the plan for Kwun Tong, was at best, a crude land zoning scheme that has since proved quite inadequate. The zoning serves mainly to separate industrial and residential land, the industries occupying the land south of the main Kwun Tong Road (Figure 4.5). Sites within the area were distributed to Government departments, but the town planners had little control over the final use of the sites or the timing of their development as has been seen in the allocation of the sites that the UCH site was chosen from.

Kwun Tong is, by Hong Kong standards, a large area, and over the years, a programme of land levelling has continued to provide sites for development. This has led to the steady increase in population and activity to beyond the level with which much of the infrastructure is capable of dealing. This was particularly so in the 1970s when Kwun Tong was linked to the rest of urban Kowloon by a single road (Figure 4.6). Social, health and educational facilities all appear to be lacking in comparison with other areas of Hong Kong. Official rationale is reflected in the imprecise statement of one Government planner who argued that "Kwun Tong was not designed as a self-contained community because it is located within two or three miles of Kowloon" (Wigglesworth, 1971, p. 52).
4.5 The isolation and integration of Kwun Tong

In the early 1970s, when the planners of the United Christian Hospital were first considering the hospital's service area, Kwun Tong was an isolated part of the urban fabric. Their argument that, given this isolation, the service area should be as self-contained as possible, was strong. This was especially so for Accident and Emergency services. Serious bottlenecks existed within Kwun Tong and the external links were overloaded. Before the United Christian Hospital was built, a trip to the nearest AED at Queen Elizabeth could take Kwun Tong residents an hour or more.

Since then, the situation has eased. Major road schemes, as shown in Figure 4.6 have opened up new links with other urban areas and the developing New Territories, although considerable congestion remains and journey times are long. Links will develop further as shown in Figure 4.6. Such transport developments and the greater mobility that results may make service area boundaries more permeable. With the East Harbour Crossing, people in Eastern District on Hong Kong Island will have quicker access to UCH's AED than they have at present to the AED at Tang Shui Kin. When the Pamela Youde Hospital is eventually opened in Chai Wan, Kwun Tong residents will have relatively easy access to it and may utilize it, given the overprovision of beds on Hong Kong Island (3.10). Until the Haven of
Hope Hospital is rebuilt with AED facilities, the nearest AED for the residents of Junk Bay New Town will be UCH.

In Hong Kong, the urban areas have always operated interdependently, a factor that may raise questions as to whether hospital service area boundaries should ever be impermeable. One survey conducted in 1971 when links were very poor found that 56.5% of the Kwun Tong working population worked outside the Kwun Tong district. Only 32% of the active male household heads living in the Kwun Tong district actually worked within the district. Of factory workers employed in Kwun Tong, only 52.9% were found to live within the district (King and Chan, 1972). This reflects in part, the high degree of labour mobility in Hong Kong and also the extent of migration into the area, with people maintaining jobs they had before they moved. It is unlikely that the situation has changed with the Mass Transit Railway aiding long distance commuting. In a systematically sampled survey of 200 paramedical and non-medical staff at UCH, conducted as part of this thesis research in 1987, it was found that 97 (48.5%) had home addresses outside the Kwun Tong District (accommodation is provided for most doctors and for unmarried nursing staff on site). Whilst more qualified staff can be seen to commute a range of distances, there is a tendency for less skilled workers to come from within the Kwun Tong area as is seen in Table 4.1 below.
Table 4.1

<table>
<thead>
<tr>
<th>Place of residence of lower grade staff at UCH, 1987</th>
<th>(based on 20% systematic sample)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Living within Kwun Tong</td>
</tr>
<tr>
<td>Amahs (Domestics)</td>
<td>27</td>
</tr>
<tr>
<td>Laundry workers</td>
<td>7</td>
</tr>
<tr>
<td>Lab technicians</td>
<td>4</td>
</tr>
<tr>
<td>Cooks</td>
<td>4</td>
</tr>
<tr>
<td>Low grade clerical</td>
<td>12</td>
</tr>
</tbody>
</table>

However, even within these groups there is evidence of workers commuting considerable distances. For instance, 8 of the clerical workers lived in New Towns in the New Territories.

Data of place of residence of the 266 hospital volunteers active in 1987 also shows the readiness of people to move considerable distances even for voluntary work. Some 60.2% of volunteers live outside the Kwun Tong District and as Figure 4.7 shows some are prepared to travel from the New Territories and even one from the Outlying Islands.

Migration into Kwun Tong has been considerable. In the 1986 By-census, it was found that 22.4% of Kwun Tong residents aged more than 5 years old, had been residing outside Kwun Tong 5 years before. The By-census also
Figure 4.7 Residential location of UCH volunteers living outside Kwun Tong
revealed that 2.8% of the population are estimated to have come to Kwun Tong from outside Hong Kong in the 5-year period prior to enumeration (HK Govt., 1987b). Unfortunately, published census returns do not indicate the nature of migrations out of Kwun Tong. These are definitely occurring, especially of younger people moving to the New Towns. A major social survey undertaken in 1971 sought to ascertain the reasons for migration into the Kwun Tong District. "Push" factors accounted for 73.5% of in-migrations (eviction from residence, lack of space, resettlement on land from boats) and "pull" factors accounted for 21.9% (attractive living conditions, lower rent and convenience for job) (cited in King and Chan, op.cit.) Since then, the situation may have changed with higher standards of public housing completed and the increased availability of Home Ownership Scheme flats within Kwun Tong.

Mobility has implications for health in the service area. Correlation of disease with possible causal factors, of great interest to community health advocates, becomes difficult for diseases developing over a long time span or where residents are working in such a variety of places. The movements themselves have important implications for health care and emphasise the need for a high degree of rapid feedback of information to the hospital.
4.6 Population and housing developments in Kwun Tong

Whilst there is still a considerable number of squatter households on the hillsides of Kwun Tong (Figure 4.5), most of the population increase has been associated with Government housing programmes. In 1986, 4.9% of the Kwun Tong households were found to be occupying simple stone buildings, huts or roof-top structures and an additional 4.4% of households were occupying temporary huts managed by the Housing Authority (HK Govt., 1987b). However, a majority of Kwun Tong's households (60.2%) occupy permanent accommodation built by the Hong Kong Housing Authority and its predecessors. Only 20.6% of Kwun Tong households are living in private residential developments while an additional 7.2% have bought their own homes under the Housing Authority's Home Ownership Scheme.

Public Housing construction has thus been fundamental to Kwun Tong's development. Details of the major housing schemes completed between 1959 and 1989 are indicated in Figure 4.5. There is such a wide variety of housing in the public sector that it is unwise to suggest that the inhabitants have uniform characteristics. It is possible that the construction date may signify a particular age structure (the newer estates having a larger proportion of younger families) which will have implications for health needs. This is difficult to ascertain. Housing Authority regulations discourage families revealing when youngsters...
have "left the nest" so the officially registered population may not reflect exactly those actually in residence.

The public housing programme in Hong Kong dates from 1956 and has been well documented (Pryor, 1973; Dwyer, 1971). In the face of mass migrations from China and a shortage of land, the Government has pursued a high-rise building programme that has few parallels elsewhere. Overall, some 40% of the population has been housed by the Government, but this considerable achievement has been at a cost in financial terms and in terms of standards. Space allocations are very low and some of the Kwun Tong estates built in the 1960s and 1970s, were planned with minimal imagination and service provision. There have been subsequent cases of construction failure, necessitating demolition. The earliest estates at Jordan Valley (Figure 4.5) and Tsui Ping Road were redeveloped in the late 1980s.

Until the 1970s, the housing programme in Hong Kong and in Kwun Tong was primarily aimed at squatter resettlement. The Resettlement Department built the Mark 1 estates at Tsui Ping Road and Jordan Valley (Figure 4.5) in 1959 and 1960. These consisted of very basic H-Blocks, 7 storeys high with no lifts and with communal toilets. The balconies acted as corridors and kitchens. They were built
as emergency housing, often accommodating the victims of squatter fires and are at present being demolished. These were followed by the Mark 3 estates at Lower Sau Mau Ping (Plate 3) and at Yau Tong in the mid-1960s which also had communal toilets but were of a higher standard. In the late 1960s, the Marks 4, 5 and 6 estates were built with self-contained units in 15-storey blocks in which lifts stopped every fourth floor. (Upper Sau Mau Ping (Plate 3), Lower Ngau Tau Kok and Lam Tin).

Concurrent with this resettlement programme, the Government low-cost housing programme (higher standard for lower income families not covered by squatter resettlement) was responsible for Ko Chiu Road, Upper Ngau Tau Kok and the Lei Yue Mun Road estates. The Hong Kong Housing Society built the two Garden Estates in the 1960s, providing the highest standards of public housing then on offer.

Public housing took on a new impetus in the 1970s with the incorporation of the Resettlement Department into a new Housing Authority responsible for all public housing initiatives. In Kwun Tong, the Housing Authority developed new estates with improved design and greater attention to environmental factors and estate layout. The first of the improved standard estates (Plate 5) was built on newly levelled land in north west Kwun Tong (e.g. Shun On
Estate) where the first Home Ownership Scheme flats were built in the early 1980s. These were followed by Lok Wah Tsuen (Plate 4) and represent the highest standard of public rental housing today. The H-blocks in Tsui Ping Rd (Plate 2) have been replaced by newer blocks and Home-Ownership flats have been built nearer the centre and in Lam Tin. At Kowloon Bay, on the borders of the District the large Kai Yip estate has been built. Future developments will be concentrated in the eastern part of the District on newly levelled sites adjacent to Lam Tin. With these estates, the public housing programme in Kwun Tong will largely be completed, except for redevelopment of older estates.

Although recent years have seen more private sector building in the Kwun Tong District, especially in the Ngau Tau Kok and Crocodile Hill areas (Plate 4), the private housing stock dates back mostly to the 1950s and 1960s. Much of this is in the form of tenement blocks where the flats, if they had ever been self-contained in the first place, have been subdivided and re-let. Since the late seventies, private developments have included the construction of Telford Gardens, a middle income estate, housing some 20,000 on a podium over the Mass Transit Railway yards at Kowloon Bay. This type of large scale development, common elsewhere in Hong Kong, is largely absent from Kwun Tong due to a lack of suitable sites. However, when the Shell oil depot is relocated in the
early 1990s, a prime site will be released for large scale development of this type.

Most commercial development has taken place away from the old overcrowded town centre, for example in the shopping arcades of Telford Gardens, in Ngau Tau Kok and in the new estates where accommodation is provided for a wide range of uses such as restaurants, supermarkets and wet markets, often located around pedestrian precincts. The absence of a clear city centre is significant. Again, Kwun Tong can compare its plight with the New Towns, each with their cultural complex and centralized sports facilities. Kwun Tong stands as an example of the problems created by the rapid and haphazard growth that Hong Kong has experienced in post-War years. Despite infrastructural investments, and the new higher quality developments mainly on the periphery, considerable difficulties remain.

The most significant characteristic of the Kwun Tong area for a community hospital initiative has been the rapidly changing urban scene. Changes have occurred in terms of population size but over the past twenty years there has also been other noticeable change as populations in some estates have aged. It has been difficult for a hospital to keep tabs on changes and to be able to monitor these in terms of changing needs. At the same time, the increases in total population have created great pressures on existing facilities and resources.
For a place to be regarded as a community it should "have a recognizable geographical area; an internal network of social communication; and a sense of identity for its residents" (King and Chan, op.cit. p.5). It has been shown that Kwun Tong does have a physical identity. King and Chan felt that it was "primarily due to its physical separateness that Kwun Tong strikes people as a community" (p.33) and little else. Suggesting that social interaction could be indicated through an analysis of telephone calls, they found that of calls handled by the Kwun Tong exchanges, only 21.53% were between Kwun Tong addresses. Some 42.2% of calls were made to places outside Kwun Tong, while the remaining 36.1% were made to Kwun Tong addresses from outside. This reflected not only social interaction but also Kwun Tong's economic interdependence with other areas, already suggested by the data on employment given. King and Chan cited traffic survey data showing that peak-hour movements out of Kwun Tong were 10% heavier than movements in.

King and Chan found too, that in terms of industrial production, Kwun Tong also looks out. Some 76% of its garment production was estimated to be exported abroad with only 0.1% being sold within the Kwun Tong area. Only in the food, beverage and tobacco industries and in paper products and printing industries did Kwun Tong consumption
account for more than 30% of production. When questioned in 1987 as part of this thesis research, purchasing staff at the United Christian Hospital listed only groceries, plastic bags, venetian blinds, stationery, medicine bottles and paper towels as products they bought from the Kwun Tong area.

Sense of identity is difficult to measure. Identity with place is not generally regarded as significant in Hong Kong, but as mentioned in the Introduction, there is still likely to be some "consensus identity" of place. Certainly amongst medical doctors, Kwun Tong is not regarded as a favoured place to live. In their 1971 survey, King and Chan found that almost two thirds of the residents showed "dislike" for Kwun Tong or no positive attachment to it.

As the example of the Eastern District Hospital Coalition has shown (3.14), it is possible in Hong Kong for some identity for area to be displayed in connection with a particular cause. This has also been witnessed in Kwun Tong, where UCH has deliberately tried to foster links with the District Board, who have been able to muster support within the area to raise over £400,000 for the hospital in sponsored walks and other such "communal" activities. The Kwun Tong District Board is one of the more active of the district boards. Kwun Tong was chosen as a pioneer District in the Government's experimentation with District Boards and since then, Kwun Tong residents
have shown themselves to be more enthusiastic participants in elections than those in other districts, but even this involvement is at a low level. The District Board remains an advisory body in the main, with few powers, a situation that is unlikely to change since it is believed that China is particularly against the development of local government in Hong Kong. Without powers, it is harder for it to be able to foster any particular political identity for the District. It cannot be said that it is representative of a community with common aspirations and priorities but perhaps this may never be possible for a city area of 700,000 people.

If community does not seem to exist on the large District scale, then on what scale does it exist? The estates of Kwun Tong have large populations. Sau Mau Ping (Plate 3) for instance, has housed as many as 130,000. Each block can house 2000 or more, each corridor, more than 100. Where does one begin to find spatial communities in this kind of situation? These, arguably, should have been major questions to tax an organization such as UCMS, whose philosophy is so closely connected with community health care. In practice, the question has, over the years, been increasingly avoided, with more recent activities of the organization treating the spatial community almost as an irrelevance as the description of the various programmes below will show.
4.8 The operation of Medical Services within the service area

As seen, there is a tendency for Hong Kong hospitals to view themselves in isolation from other health care providers. Such an isolationist stance is untenable for a hospital with aspirations towards establishing an interactive service area, an essential aspect of community health. In the interests of health promotion, disease prevention, screening, targeting specific groups and encouraging responsible and efficient use of hospital resources, co-operation and co-ordination within the service area are needed. The principles of intersectoral collaboration must be followed. For any hospital in Hong Kong, this is problematic. Not only is there a plethora of different care services at work, these also span the private, subvented and Government sectors and the western and traditional spheres. These different providers may have few conventions of co-operation. The eclectic nature of health care seeking with the consumer playing a dominant role, works against co-operation between services.

Service provision in Kwun Tong is shown diagramatically in Figure 4.8. As there is no formal registration, a clear idea of numbers of traditional practitioners can only be obtained through a detailed street survey. This has not been done since 1971, when Lee (1973) found 109 herbalists, 49 bonesetters, 12 acupuncturists and 4
Figure 4.8  The Kwun Tong health system

Unregistered Doctors
Herbalists
Acupuncturists
Bonesetters
Private doctors
X-ray & Medical Laboratories
Private doctors
Charity doctors
Private dentists
Private beds
Social Welfare Department & Agencies
Health Education
Community Development
Volunteers
Health Centres
C.N.S.
Health Maintenance Programs
Infant
School
Industrial
Geriatric
General O.P.D.
Specialist O.P.D.
A.E.D.
Hospital Beds
F.P.A.

FPA = Family Planning Association
+++ = health promotion activities
arrows show patient movements
= ambulance cases
(After Paterson, 1977 op.cit.)
haemorrhoid specialists in practice along with western doctors in 43 private clinics, 14 religious non-profit clinics and 7 secular non-profit clinics. In informal interviewing of CNS patients in Kwun Tong as part of this thesis research (see Introduction for discussion of this), over one third of those visited admitted regular use of traditional medicines or medical practices but with one exception, these were aged over 65 years (see Table 4.2.1).

The first western medical services in Kwun Tong were in non-profit clinics set up in the late 1950s. The Kwun Tong Jockey Club Health Centre (a large Government outpatient clinic with maternity beds) was opened in 1964. The first private practice was not established until 1965 (Chan, 1972) possibly reflecting the low economic status of the local population at that time. In the early days, the services reflected the urgent needs of recent refugees. For instance, the Family Planning Association opened its first clinic in Kwun Tong in 1962, followed by another two in 1965 and others in 1966, 1969 and 1970.

The location of Government and subvented facilities are shown in Figure 4.9. Although private GPs are present in the housing estates, some functioning under the auspices of the Estates Doctors Association, there is a concentration of private profit-making practice in central Kwun Tong and in Ngau Tau Kok. Such a concentration of
### Table 4.2.1 CNS home visits - admitted use of Chinese medicines

<table>
<thead>
<tr>
<th>AGE</th>
<th>SEX</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>F</td>
<td>herbs used for common colds</td>
</tr>
<tr>
<td>82</td>
<td>F</td>
<td>medicines used for common colds</td>
</tr>
<tr>
<td>68</td>
<td>F</td>
<td>herbal teas used for common colds</td>
</tr>
<tr>
<td>70+</td>
<td>F</td>
<td>medicines for common colds</td>
</tr>
<tr>
<td>67</td>
<td>M</td>
<td>herbal brew for strengthening the body</td>
</tr>
<tr>
<td>38</td>
<td>F</td>
<td>herbal teas for strengthening the body</td>
</tr>
<tr>
<td>80</td>
<td>F</td>
<td>medicine for knee joint pains</td>
</tr>
<tr>
<td>71</td>
<td>M</td>
<td>medicine for dressing fistula</td>
</tr>
<tr>
<td>33</td>
<td>F</td>
<td>medicines when feeling uncomfortable</td>
</tr>
<tr>
<td>70</td>
<td>F</td>
<td>acupuncture and traditional tablets for stroke</td>
</tr>
<tr>
<td>73</td>
<td>F</td>
<td>acupuncture and herbal teas for stroke</td>
</tr>
<tr>
<td>70</td>
<td>F</td>
<td>medicines for general ailments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 said they were afraid to mix western &amp; traditional medicines</td>
</tr>
</tbody>
</table>

### Table 4.2.2 CNS home visits - use of GPs

<table>
<thead>
<tr>
<th>Use of:</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private GPs</td>
<td>15</td>
</tr>
<tr>
<td>Kwun Tong Community</td>
<td>3</td>
</tr>
<tr>
<td>Health Project GPs</td>
<td></td>
</tr>
<tr>
<td>Government Clinics</td>
<td>5</td>
</tr>
<tr>
<td>No use of GPs</td>
<td>6</td>
</tr>
<tr>
<td>No answer given</td>
<td>2</td>
</tr>
</tbody>
</table>

Use of same GP each time needed 5

### Table 4.2.3 CNS home visits - reasons for choice of UCH for admission/consultation

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional referral</td>
<td>10</td>
</tr>
<tr>
<td>Convenience/ nearness</td>
<td>11</td>
</tr>
<tr>
<td>Ambulance decision</td>
<td>5</td>
</tr>
<tr>
<td>Recommendation of others</td>
<td>2</td>
</tr>
<tr>
<td>No reason given</td>
<td>1</td>
</tr>
</tbody>
</table>
doctors suggests that GPs do not generally consider themselves to be serving any particular area of population. A premium is placed on overall accessibility in areas where people congregate for other purposes and where maximum exposure is guaranteed as well as being where rents are highest. Proximity to others offering the same service (a tradition of many services and retailers in Hong Kong) is not considered a drawback, given the doctor shopping habits which this arrangement both caters to and encourages. Of the 31 CNS patients questioned as part of this thesis research (see Tables 4.2.1 to 4.2.3), only 5 stated that they used the same GP each time a doctor was needed. These were elderly patients who used two particular estate-based GPs who charged low fees. The concentration of GPs in the more central parts of the Kwun Tong District poses problems of physical accessibility which may account for the failure of some interviewees to use a GP at all, although for some of these, financial considerations were also evidently important.

Generally, private non-profit clinics choose less central locations, partly to avoid the high rentals and partly because of their eligibility for Housing Authority sites near to their target populations. In his Kwun Tong study, Lee hypothesised that "the better the quality of residential housing and the larger the population size, the greater... the numbers of different kinds of medical and health services in particular regions of the Kwun Tong
community" (Lee, 1972, p6). He concluded that population size accounts for 81% of variations in the distribution of Chinese health care units; 74% of variation in drug store distribution and 42% of the distribution of western health care units. He argued that western care was more likely to be located nearer to areas of higher housing quality. However, these conclusions are based on a rating scheme for housing quality that gave private housing a higher score than Government housing. Given that much of the private housing in Kwun Tong at that time was subdivided tenement housing of a very low standard, this assumption may be challenged. It may be that the central location and premise availability were also important location factors and these were not included in his statistical analysis.

Data for individual Government clinics are not available and it is difficult to assess the performance of Government clinics in Kwun Tong. On the basis of the Government planning ratio of one large clinic per 100,000 population and one specialist clinic per 500,000, Kwun Tong should have at least 6 clinics and 1 polyclinic in operation. There are 2 general clinics in full operation with 1 satellite clinic (Shun Lee Clinic - see Figure 4.9) offering a general out-patient service during the day and early evening. At one of the clinics, there are methadone maintenance services at night. Both the full sized Government clinics have maternity beds. These two clinics are located very close to each other near the centre of
Figure 4.9 The location of Government and other hospital-related facilities in Kwun Tong
Kwun Tong. They have no formal service areas and records are not kept. They offer a walk-in, no appointment service which generally involves very long queues. At the Ko Chui Road Estate, the Government operates a Maternal and Child Health Care centre. Two Polyclinics have been built (Figure 4.9) but in 1988, neither operated as such. The Yung Fung Shee/East Kowloon Polyclinic has a psychiatric and geriatric day hospital but these function completely independently of United Christian Hospital. If the polyclinics are intended for specialist outpatient services for Kwun Tong residents attending Government hospitals (the way polyclinics in Hong Kong are supposed to operate), it is hard to see why two are needed. No attempt has been made by the MHD to offer polyclinic services to UCH, nor was UCH consulted over their planning, providing further evidence of haphazard health care planning and the lack of co-ordination between Government and subvented sectors. The maternity beds at the two Government clinics have no formal links with the Obstetrics and Gynaecology Department at UCH although they do refer complications to the hospital or to UCH CNS.

Some indication of referral patterns to UCH is given by Table 4.3. This shows that in the week surveyed only 18.3% of the referrals to specialist outpatients at UCH came from GPs. The Kwun Tong MHD clinics referred 14.6% of the cases whilst 42.5% were cases referred from walk-in services at UCH.
**Table 4.3 New cases at UCH Outpatients**
Evidence from a one week survey, November, 1987

<table>
<thead>
<tr>
<th>Referred from</th>
<th>UCH Community Clinic</th>
<th>UCH AED</th>
<th>KTCHP clinic</th>
<th>MHD clinic in Kwun Tong</th>
<th>GP</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Surgery</td>
<td>16</td>
<td>25</td>
<td>4</td>
<td>16</td>
<td>21</td>
<td>5</td>
</tr>
<tr>
<td>Medicine</td>
<td>7</td>
<td>19</td>
<td>0</td>
<td>4</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Ear/nose/throat</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Gynae</td>
<td>15</td>
<td>8</td>
<td>1</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Eye</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>6</td>
<td>17</td>
<td>0</td>
<td>7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Cleft lips/palates</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>87</td>
<td>6</td>
<td>39</td>
<td>49</td>
<td>33</td>
</tr>
<tr>
<td>as %</td>
<td>19.9</td>
<td>32.6</td>
<td>2.3</td>
<td>14.6</td>
<td>18.3</td>
<td>12.4</td>
</tr>
</tbody>
</table>
Under the regionalization scheme, UCH is still regarded officially as one of the "District Hospitals" as these were conceived in the 1974 White Paper, but which have never operated as such. In many respects, UCH operates as a regional hospital. UCH receives very few referrals from the main regional hospitals and most patients entering it are not referred elsewhere. In response to overcrowding and to clinical restraints there are some tertiary referrals from UCH elsewhere. This amounted to 1,117 inpatients in 1987, and 8,867 attenders at AED. A breakdown of inpatients and AED attenders transferred is given in Table 4.4. AED attenders are generally transferred to QEH (as the Regional Hospital) when no space is available at UCH. Referrals to Castle Peak are for psychiatric cases (the UCH psychiatric unit is an acute voluntary unit). Other transfer destinations are chosen on the basis of place of residence of attender. AED attenders may also be referred to QEH and Prince of Wales of Hospital in Shatin for scans or to Kwong Wah Hospital for head scans. Transfers for diagnosis account for most of the transfers of inpatients to POWH. Transfers for cancer therapy occur to both QEH and Nam Long. Haven of Hope acts as a convalescent hospital for UCH orthopaedic cases.
<table>
<thead>
<tr>
<th>Hospital referred to</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth</td>
<td>8,194</td>
</tr>
<tr>
<td>Castle Peak (psychiatric)</td>
<td>173</td>
</tr>
<tr>
<td>Princess Margaret</td>
<td>167</td>
</tr>
<tr>
<td>Prince of Wales</td>
<td>116</td>
</tr>
<tr>
<td>Others</td>
<td>217</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8,867</strong></td>
</tr>
<tr>
<td><strong>Inpatients</strong></td>
<td></td>
</tr>
<tr>
<td>Queen Elizabeth</td>
<td>55</td>
</tr>
<tr>
<td>Prince of Wales</td>
<td>242</td>
</tr>
<tr>
<td>Castle Peak</td>
<td>8</td>
</tr>
<tr>
<td>Haven of Hope</td>
<td>521</td>
</tr>
<tr>
<td>Others</td>
<td>291</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,117</strong></td>
</tr>
</tbody>
</table>
4.9 The Utilization of UCH by its service area

The United Christian Hospital is the only acute-general hospital in the Kwun Tong District and is indeed the only acute-general with AED, east of Queen Elizabeth (see Figure 3.2). As a subvented hospital, its budget (£16 million in 1989) is strictly controlled by the MHD. However, its day-to-day management is independent of Government, the administrators answering to a Management Committee and ultimately to the Executive Committee of the United Christian Medical Service (UCMS), the constitutional body responsible for the hospital. UCMS is also responsible for the non-subvented Kwun Tong Community Health Project, which was established in 1972 to promote community health ideas within the hospital's service area and to foster links between the hospital and the Kwun Tong District. The hospital recruits its own staff and trains its own nurses in the Nethersole School of Nursing which is on site. Staff are paid according to Government pay scales without many of the Civil Service fringe benefits. Compared with Government hospitals, there are comparatively few senior medical posts and this has affected recruitment at the department head level.

The hospital opened in 1973 with 350 beds but has since had a history of growth. What started out as a small church hospital with little going for it, has developed into the key provider of hospital care for eastern New

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Kowloon. Even before its opening, the Government announced funding for immediate expansion to 545 beds, which was achieved by 1976. The growth in capacity and work load is shown in Table 4.5. Currently, the hospital deals with some 30,000 admissions a year and employs a staff of over 1500, including 240 fully qualified nursing staff and over 80 doctors excluding housemen and externs. It is thought generally to be regarded as a popular hospital, although the reasons given by interviewees on CNS visits (Table 4.2.3) indicate more pragmatic reasons for choice than simply preference.

The hospital is now undergoing reprovisioning and expansion to 1,432 beds by 1995 at a capital cost in excess of £80 million, to be found almost entirely from public funds. Existing services and departments are to be expanded and upgraded whilst additional services are being introduced. The proposed facilities and services are given in Table 4.6. The increased scale of operation will make viable certain additional facilities, such as a burns unit, that might now be regarded as essential for a modern industrial area.

Plans for the expansion were based on experience of demand and only very loosely on projections based on population forecasts. Feedback of information from experience of community health care in the Kwun Tong District did not
<table>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MEAN STAY (days)</td>
<td>7.4</td>
<td>7.5</td>
<td>7.8</td>
<td>7.9</td>
<td>7.6</td>
<td>7.2</td>
<td>6.9</td>
<td>6.9</td>
<td>6.8</td>
<td>6.8</td>
</tr>
<tr>
<td>OVERALL OCCUPANCY %</td>
<td>82.2</td>
<td>84.7</td>
<td>88.2</td>
<td>91.7</td>
<td>90.1</td>
<td>89.1</td>
<td>88.6</td>
<td>91.0</td>
<td>90.1</td>
<td>88.9</td>
</tr>
<tr>
<td>OUTPATIENT ATTENDANCES</td>
<td>194419</td>
<td>190426</td>
<td>193685</td>
<td>215729</td>
<td>224036</td>
<td>248212</td>
<td>239492</td>
<td>249226</td>
<td>254338</td>
<td>247183</td>
</tr>
<tr>
<td>AED ATTENDANCES</td>
<td>101678</td>
<td>119433</td>
<td>126351</td>
<td>123970</td>
<td>128478</td>
<td>118277</td>
<td>113350</td>
<td>134016</td>
<td>136719</td>
<td>145747</td>
</tr>
<tr>
<td>BABIES BORN</td>
<td>3461</td>
<td>3334</td>
<td>3367</td>
<td>3477</td>
<td>3714</td>
<td>3398</td>
<td>3327</td>
<td>3300</td>
<td>2905</td>
<td>3086</td>
</tr>
<tr>
<td>OPERATIONS</td>
<td>7719</td>
<td>7786</td>
<td>9379</td>
<td>9451</td>
<td>9808</td>
<td>11127</td>
<td>10923</td>
<td>10937</td>
<td>10532</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.6 Planned provision in extended UCH

<table>
<thead>
<tr>
<th>Bed use/function</th>
<th>Present provision</th>
<th>Planned provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal medicine</td>
<td>135 beds</td>
<td>240 beds</td>
</tr>
<tr>
<td></td>
<td>(113% occupancy)</td>
<td></td>
</tr>
<tr>
<td>Paediatric</td>
<td>66 beds/cots</td>
<td>135 beds/cots</td>
</tr>
<tr>
<td>Newborn special care unit</td>
<td>22 cots/incubators</td>
<td>40 cots/incubators</td>
</tr>
<tr>
<td>Obstetric</td>
<td>40 beds</td>
<td>120 beds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 private rooms</td>
</tr>
<tr>
<td>Geriatric</td>
<td>40 beds</td>
<td>120 day/inpatient places</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20 place hospice</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>30 beds</td>
<td>152 beds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80 day places</td>
</tr>
<tr>
<td>Private</td>
<td></td>
<td>38 beds</td>
</tr>
<tr>
<td>Surgical</td>
<td>140 beds</td>
<td>308 beds</td>
</tr>
<tr>
<td></td>
<td>(96.5% occupancy)</td>
<td>incl trauma</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>100</td>
<td>176 beds</td>
</tr>
<tr>
<td></td>
<td>(98.4% occupancy)</td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>45 beds</td>
<td>44 beds</td>
</tr>
<tr>
<td></td>
<td>(53% occupancy)</td>
<td></td>
</tr>
<tr>
<td>Intensive care</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>(100% occupancy)</td>
<td>excl coronary</td>
</tr>
<tr>
<td>Coronary care</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Burns unit</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Day surgery</td>
<td></td>
<td>20 beds</td>
</tr>
<tr>
<td>Renal dialysis</td>
<td>3 positions</td>
<td>18 positions</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gamma camera</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CT scan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>improved ultrasound</td>
</tr>
</tbody>
</table>

Source: UCH planning brief
play a significant role. Instead needs, as expressed by medical professionals, have been instrumental in the design and specification of the expanded hospital. In this respect, the expanded UCH will reflect the prevailing hospital philosophy. This is also seen in its large size.

When expansion proposals were first discussed in 1979, just six years after UCH's opening, one dissenting voice on the UCMS Board asked if the hospital crisis, "if there is indeed a crisis", would be solved by "having the Christian community get more involved in the building and administering huge hospitals when the Hong Kong Government has accepted the responsibility to provide medical services for its people" (internal restricted circular, 1979). The member argued that the crisis was not in the hardware "but more a crisis of the spirit and leadership" asserting that "(w)e Christians are failing not because we have not provided adequate medical facilities but because we have not really and seriously defined and developed our ideas about health and the healing community". Instead resources should be directed to the Kwun Tong Community Health Project which he noted was far from achieving its original objectives, to develop a model of Christian medical care, for "(u)ntil that model is sufficiently developed for the community to see that UCH is really a caring and human hospital, any expansion will only recreate and compound the problems and the image we now have".
Perhaps because of the disappointment with the Kwun Tong Community Health Project (KTCHP), and certainly because of the very real pressures of excessive demand experienced by UCH, the Board supported expansion. An overloading of facilities in the late 1970s resulted in several instances of litigation. As a result of one much publicised case, MHD was forced to recognize the paucity of staffing at UCH AED, but while staffing levels may have improved, pressure on the physical facilities has not eased. UCH remains an extremely busy hospital dealing in a wide range of acute work (see Tables 4.7.1 and 4.7.3). Unlike the major regional hospitals, the only recourse to convalescent beds that UCH has is to 80 beds at the Haven of Hope Hospital. This access will end, when Haven of Hope is redeveloped as an acute-general in the early 1990s. It has already been noted how UCH transfers inpatients and AED attenders to other hospitals but even in doing this, it is still unable to avoid exceeding capacity on occasions and having to use corridor and camp beds. The situation in what might be regarded as a typical month, is indicated in Table 4.7.2.

4.10 Utilization of United Christian Hospital

An idea of utilization patterns for UCH has been obtained from a survey of inpatient records for 1980-81 (see Introduction for discussion on methods). A 10% systematic sample of entries in the in-patient register was taken for
Table 4.7  UCH Operational statistics for September, 1987
(Source: UCH monthly statistical returns)

4.7.1 Accident & Emergency Department attendance

<table>
<thead>
<tr>
<th>TYPE</th>
<th>ADMITTED TO OTHER HOSPITAL</th>
<th>ADMITTED EMERG</th>
<th>NOT ADMITTED N/EMERG</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAUMA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault</td>
<td>18</td>
<td>12</td>
<td>193</td>
<td>10</td>
</tr>
<tr>
<td>Traffic</td>
<td>24</td>
<td>19</td>
<td>174</td>
<td>18</td>
</tr>
<tr>
<td>Industrial</td>
<td>70</td>
<td>36</td>
<td>1365</td>
<td>123</td>
</tr>
<tr>
<td>Domestic</td>
<td>50</td>
<td>25</td>
<td>459</td>
<td>45</td>
</tr>
<tr>
<td>Animal bite</td>
<td>6</td>
<td>3</td>
<td></td>
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</tr>
<tr>
<td>Sport</td>
<td>10</td>
<td>5</td>
<td>64</td>
<td>6</td>
</tr>
<tr>
<td>Insect bite</td>
<td>10</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>25</td>
<td>23</td>
<td>277</td>
<td>18</td>
</tr>
<tr>
<td>Total traumatic</td>
<td>197</td>
<td>126</td>
<td>2557</td>
<td>225</td>
</tr>
<tr>
<td>NON TRAUMA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB</td>
<td>1</td>
<td></td>
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</tr>
<tr>
<td>Medical</td>
<td>445</td>
<td>312</td>
<td>1742</td>
<td>1149</td>
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<tr>
<td>Surgical</td>
<td>273</td>
<td>169</td>
<td>394</td>
<td>121</td>
</tr>
<tr>
<td>Obstetric</td>
<td>18</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>102</td>
<td>2</td>
<td>91</td>
<td>25</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>225</td>
<td>28</td>
<td>706</td>
<td>595</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>2</td>
<td>23</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>74</td>
<td>35</td>
<td>128</td>
<td>48</td>
</tr>
<tr>
<td>Dental/Opthalmic/ENT</td>
<td>5</td>
<td>24</td>
<td>224</td>
<td>66</td>
</tr>
<tr>
<td>Others</td>
<td>9</td>
<td>38</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Total non-trauma</td>
<td>1144</td>
<td>609</td>
<td>3348</td>
<td>2047</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1341</td>
<td>735</td>
<td>5905</td>
<td>2272</td>
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</table>

4.7.2 UCH Department bed occupancy

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>MEAN % OCCUPANCY</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>93.3%</td>
<td>for 3 days &gt; 100%</td>
</tr>
<tr>
<td>Medicine</td>
<td>107.9%</td>
<td>only 3 days &lt; 100%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>93.9%</td>
<td>1 day &gt; 100%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>51.3%</td>
<td>1 day as low as 25%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>92.4%</td>
<td>11 days &gt; 100%</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>84.7%</td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td>64.9%</td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td>47.6%</td>
<td></td>
</tr>
<tr>
<td>Private beds</td>
<td>54.1%</td>
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4.7.3 Operating Theatre Department statistics

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<th>TYPE</th>
<th>LIST</th>
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<th>TOTAL</th>
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<td>Gastro-Intestinal tract</td>
<td>major</td>
<td>29</td>
<td>21</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>minor</td>
<td>41</td>
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<td>70</td>
</tr>
<tr>
<td></td>
<td>endoscopy</td>
<td>96</td>
<td>62</td>
<td>158</td>
</tr>
<tr>
<td>Genito-urinary tract</td>
<td>major</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>minor</td>
<td>46</td>
<td>3</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>endoscopy</td>
<td>22</td>
<td>0</td>
<td>22</td>
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<tr>
<td>Endocrine</td>
<td></td>
<td>9</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Minor excision (inpatient)</td>
<td></td>
<td>76</td>
<td>13</td>
<td>89</td>
</tr>
<tr>
<td>Minor outpatient surgery</td>
<td></td>
<td>72</td>
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<td>72</td>
</tr>
<tr>
<td>Arterial</td>
<td></td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Thoracic</td>
<td>major</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>minor</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>endoscopy</td>
<td>9</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Plastic</td>
<td>cleft lip</td>
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<td>0</td>
<td>3</td>
</tr>
<tr>
<td>ENT</td>
<td>ear</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
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<td>9</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>throat</td>
<td>11</td>
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<td>11</td>
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<tr>
<td>Neural</td>
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<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Eye</td>
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<td>4</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>major</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
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<td>22</td>
</tr>
<tr>
<td></td>
<td>hand</td>
<td>0</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Gynaecology</td>
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<td>7</td>
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</tr>
<tr>
<td></td>
<td>minor</td>
<td>42</td>
<td>29</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>endoscopy</td>
<td>15</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>major</td>
<td>7</td>
<td>15</td>
<td>22</td>
</tr>
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<td></td>
<td>minor</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sterilization</td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>female</td>
<td>38</td>
<td>0</td>
<td>38</td>
</tr>
</tbody>
</table>
the period August 1980 to July 1981. These registers provide very basic information only — age, sex, time of admission, status of admission (whether pre-booked or emergency), previous admission and address. The hospital department to which the patient was admitted in the first instance is also recorded and this is the only medical information available. These records did not include obstetric admissions. At UCH, obstetric admissions are kept separate as it was originally felt important to separate obstetrics from disease. For the purposes of this study, obstetric admissions have not been included as there is an admissions policy allowing only admissions from people living within the Kwun Tong District and even then entertaining only first deliveries, complicated deliveries, others in at risk groups and those who have agreed previously to post-partum sterilization. As far as hospital staff are concerned they implement this policy strictly. However, as conversation with community nurses and information revealed by patients on home visits, some mothers give Kwun Tong addresses of relatives in order to qualify and will then stay with those relatives after birth in order to receive community nursing visits. It is conceivable that such parents then give their correct addresses if a child is admitted to hospital afterwards.

The admission registers for the above period gave details for 22,743 non-obstetric admissions. The 10% sample of
some 2,274 patients revealed that 1,936 (85.1%) gave addresses from within the Kwun Tong District and two adjoining estates on the Kwun Tong periphery (see Table 4.8). A further 116 patients (5.1%) gave addresses in Wong Tai Sin District, the district to the west of Kwun Tong; 29 (1.3%) gave addresses in Sai Kung District to the north; with the remaining 179 (7.9%) giving addresses outside these areas. Fourteen addresses (0.6%) were unknown or could not be located. The relative importance of Districts is indicated in Figures 4.10.1 and 4.10.2.

The essential finding is the correlation between the service area as envisaged by the hospital and the origins of patients utilizing the hospital. The only other readily available information for comparison is in Table 3.11 although the areas in these cases are far larger. This data is unable to help in estimating the number of Kwun Tong residents who sought admission outside the Kwun Tong area. Set against the Kwun Tong population, the UCH admission rate is about 1 in 20 population compared with a Hong Kong average of 1 in 10. It may be that considerable numbers of Kwun Tong residents are seeking admission in hospitals outside the area. It has been seen that a patient can present at whatever public hospital she or he chooses at least as an attender of AED (with the exception of emergency ambulance cases where the patient will be taken usually to the nearest AED). Whilst formal specialist outpatient appointments can only be obtained
<table>
<thead>
<tr>
<th>PREVIOUS ADM</th>
<th>Y</th>
<th>48.4</th>
<th>46.1</th>
<th>44.8</th>
<th>48.3</th>
<th>31.0</th>
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</thead>
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<tr>
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<td>N</td>
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<td>53.9</td>
<td>55.2</td>
<td>51.7</td>
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<td>6.9</td>
<td>6.4</td>
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<td>1.5</td>
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<td>0.0</td>
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<tr>
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<td>3.5</td>
<td>3.4</td>
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<td>30-39</td>
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<td>12.1</td>
<td>6.9</td>
</tr>
<tr>
<td>40-49</td>
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<td>9.4</td>
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<tr>
<td>&gt;=60</td>
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<td>26.3</td>
<td>26.6</td>
<td>25.9</td>
<td>44.8</td>
</tr>
<tr>
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<td>M</td>
<td>50.6</td>
<td>57.6</td>
<td>59.1</td>
<td>55.2</td>
<td>41.4</td>
</tr>
<tr>
<td>E</td>
<td>F</td>
<td>49.4</td>
<td>42.3</td>
<td>40.9</td>
<td>44.8</td>
<td>58.6</td>
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Table 4.8 UCH utilization characteristics by residential origin of inpatients
Table 4.8 (continued)

<table>
<thead>
<tr>
<th>Time Block</th>
<th>Kwun Tong Overall</th>
<th>All areas outside Kwun Tong</th>
<th>All except Wong Tai Sin &amp; Sai Kung</th>
<th>Wong Tai Sin</th>
<th>Sai Kung</th>
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</thead>
<tbody>
<tr>
<td>0001-0006</td>
<td>9.5</td>
<td>6.3</td>
<td>4.9</td>
<td>8.6</td>
<td>13.8</td>
</tr>
<tr>
<td>0006-1200</td>
<td>33.9</td>
<td>28.5</td>
<td>28.1</td>
<td>29.3</td>
<td>13.5</td>
</tr>
<tr>
<td>1200-1800</td>
<td>35.9</td>
<td>39.2</td>
<td>43.8</td>
<td>31.0</td>
<td>48.3</td>
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<td>10.3</td>
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</tr>
<tr>
<td>S</td>
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<td>27.6</td>
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</tr>
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<td>P</td>
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<td>7.9</td>
<td>7.8</td>
<td>0.0</td>
</tr>
<tr>
<td>G</td>
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<td>11.0</td>
<td>9.8</td>
<td>12.9</td>
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</tr>
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<td>O</td>
<td>10.2</td>
<td>25.4</td>
<td>27.6</td>
<td>21.5</td>
<td>24.1</td>
</tr>
</tbody>
</table>

Key:

S = Surgery
M = Medicine
P = Paediatrics
G = Gynaecology
O = Orthopaedics

- 340 -
Figure 4.10.1 UCH inpatients from outside the older urban areas, 1981

UCH INPATIENTS PER 100,000 POPULATION 1981

- 341 -
Figures 4.10.2 UCH inpatients from within the older urban areas, 1981
through referral, patients can often be referred from AED or in the case of UCH, from its community clinic—a general outpatient clinic designed to take workload off the AED in daytime hours. Both AED and community clinic are walk-in services.

A GP is free to refer to any hospital and may respond to patient requests. A GP may act on the basis of old contacts from previous employment at a particular hospital or may only refer to a private specialist, which the patient may refuse to follow through. Given the highly eclectic health care seeking attitudes of Hong Kong people and a clear tendency to present at AED, it is not surprising that referrals to a hospital specialist may not be pursued by the patient. This could be a reason why some GPs give patients a referral note to take to an AED-patient freedom over which AED to attend.

It is quite possible that those giving addresses outside the Kwun Tong area might have been working within Kwun Tong at the time. This might explain the greater percentage of orthopaedic emergency admissions for those resident in areas away from Kwun Tong and the two neighbouring districts of Wong Tai Sin and Sai Kung (Table 4.8), the clear predominance of male patients and the high percentage of admissions from the 20-29 year age group, (factory operatives and construction workers being the most common group of young orthopaedic admissions).
This may also be an explanation of the predominance of admissions of such residents in the afternoon, the comparative paucity of paediatric admissions from these districts and the noticeable tailing off of admissions of such residents in early hours of morning (Table 4.8). The last three mentioned characteristics could also be associated with a distance decay away from Kwun Tong.

There is a relatively high percentage of elective cases in those non resident in Kwun Tong and neighbouring districts suggesting less likelihood of visiting the hospital "on spec". UCH offers few specialities unavailable elsewhere. In this period, ENT surgery attracted some elective cases from outside Kwun Tong as did cleft lip/palate surgery (unavailable elsewhere). One apparent anomaly is that admissions of those aged 60 and over, form a similar percentage of admissions regardless of patient origin. With these patients, admission may be associated more with a carer's place of residence rather than their own.

In Hong Kong, the term "emergency" embraces non-elective work and genuine "life-or-death" emergency. At UCH, despite the relative unimportance of elective admission, the bulk of admissions (70.2% for females and 80.8% for males) occur during the normal hospital working hours. The period from 6pm to midnight is nevertheless still important accounting for 20.6% and 20.8% of female and
male admissions respectively. The night-time period of midnight to 6 am is the least busy. This pattern plus seasonal variations, such as a noticeable fall-off in admissions around the Chinese New Year observed in the 1981 inpatient sample, indicate that although patients present as emergency cases, the decision to present appears to be influenced, at least in some cases, by personal convenience.

Much of the work load of any acute-general hospital will involve dealing with on-going cases who may be readmitted at times. This is a reason why the short-term evaluative perspective adopted in the prevailing official hospital philosophy, with its resultant careless attitude to good record-keeping is not in tune with modern medical needs. Some 48.5% of the UCH sample had a previous admission history at UCH. Such patients are far more likely to be elective patients - of all elective admissions in this sample, 83.7% had a previous admission history. Once a patient has had a particular experience of a hospital, there seems to be a tendency to use that hospital again if needed in the future. Post-discharge follow-up will be done in the admitting hospital's specialist outpatient clinics or in the case of Government hospitals, in an associated polyclinic. If complications arise, a return to the same hospital will be arranged.
There is a tendency for doctors to transfer patients presenting at AED with a known history at another hospital back to that particular hospital. This acts as one criterion for screening patients when a hospital is full. By the same token, doctors at a given hospital are under some expectation to accept those patients who have previously been admitted to it.

Given that one of the arguments for Community Health is the desirability for a hospital to learn about the health problems of its service area so that services can be tailored to those needs, some information about utilization by particular areas may be of some use. However, it is not the intention of this study to analyse reasons for utilization in depth. It must suffice to show that there is some evidence from the sample study of UCH's utilization to suggest that the different areas of Kwun Tong, at least over the period of time examined, made differential use of the hospital.

This can be seen clearly in the case of gynaecological admissions. Using the female populations for the individual areas of Kwun Tong (as obtained from the 1981 street block tabulations, HK Govt, 1982b) age-specific sample rates can be calculated on the basis of number of patients admitted (multiplied by 10 as this is a 10% sample) per thousand female population in the 20-49 year age band (84% of gynaecological admissions at UCH are of
women in this age band). As Table 4.9 indicates, there is a wide variation in these sample rates. Do areas with low rates represent women with unmet needs, greater health status or utilizing other services? Areas with rates above 1 standard deviation from the mean are found to be predominantly areas of temporary housing (i.e., areas 4, 20, 6—see Table 4.9 and Figure 4.11) or village housing (areas 37 and 40). Reasons do not suggest themselves easily. Are the higher rates simply the products of chance factors? Are they due to inaccurate census data, with populations being underestimated as illegal migrants, more likely to be found in these temporary or village housing areas avoiding enumeration? Are they the results of other characteristics of population? Is there a link with obstetric experience—areas 4, 6, and 20 (all Housing Authority temporary housing) have higher than average proportions of population aged under 4 years although this is not the case with other high rate areas such as the village area 37 and the illegal squatter area 30.

These are questions that a responsive community health initiative could address but this would depend on extensive and complex information systems, the means to analyse the information gained and above all an ability to make the service adjustments thought to be required. In a situation of scarce resources and already overloaded facilities there is little attraction in seeking new work.
Table 4.9  UCH Gynaecology admissions by Street Block

<table>
<thead>
<tr>
<th>Code</th>
<th>Area</th>
<th>No. Sexes</th>
<th>Age specific</th>
<th>% E of females aged 20-49</th>
<th>% of house holds not sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Choi Hung Estate</td>
<td>8813</td>
<td>1.1</td>
<td>45.6</td>
<td>67.2</td>
</tr>
<tr>
<td>2</td>
<td>Choi Van Estate</td>
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<td>5.7</td>
<td>40.0</td>
<td>57.8</td>
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<tr>
<td>3</td>
<td>Ping Shek Estate</td>
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<td>39.6</td>
<td>69.6</td>
</tr>
<tr>
<td>4</td>
<td>Ping Shek Resite</td>
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<td>45.0</td>
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</tr>
<tr>
<td>5</td>
<td>Telford Gardens</td>
<td>651</td>
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<td>60.8</td>
<td>23.3</td>
</tr>
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<tr>
<td>7</td>
<td>Jordan Valley Estate</td>
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<td>35.3</td>
</tr>
<tr>
<td>8</td>
<td>MTK (Amoy Area)</td>
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<tr>
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<td>Ko Chin Rd Estate</td>
<td>2310</td>
<td>34.6</td>
<td>39.3</td>
<td>48.2</td>
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</table>

Mean = 15.9
standard dev = 12.1
Figure 4.11 Attendance rate of gynaecology inpatients by Kwun Tong street blocks, 1981
At the secondary referral level, within the Kwun Tong district there is only one provider of acute-general services. In trying to develop relationships with care providers at the primary level, as already noted, great difficulties are likely to arise because of the large number of different primary service providers. Intersectoral collaboration may seem impossible in such a situation. One partial solution is for the hospital to become involved at the primary level itself, thereby gaining some control of services and through this effecting the collaboration needed. To some extent this is the thinking behind the Kwun Tong Community Health Project (KTCHP) which is dealt with in detail below. Given the Hong Kong situation, for most services, an independent agency such as KTCHP cannot have a universal impact in any area, however small the area may be. There are exceptions to this and one has been in the field of Community Nursing where there is no private practice as yet, and where through the subvention system both the provider agency and the area of monopoly are defined.

Before Government recognized the need for Community Nursing, the KTCHP was one of the agencies involved in an experimental community nursing service. Since receiving subvention, the Community Nursing Service for the Kwun
Tong area has come under the direct control of the UCH management. It now represents the most direct example of UCH outreach into its service area. Community nursing agencies in Hong Kong operate within service areas with impermeable boundaries and so UCH CNS provides all the community nursing services for patients living within Kwun Tong District.

As has been noted, the UCH CNS has the highest workload of any community nursing agency and the people of the Kwun Tong area are the best served (see 3.16). This is the result of the emphasis placed on community nursing by UCH. Community nursing was seen very much as a way of maximizing use of beds and has been instrumental in keeping UCH bed-stay figures low given its inability to transfer large numbers of patients to convalescent beds. Unlike the other CNS agencies, UCH CNS operates from a large number of bases distributed throughout its overall service area. The current locations of the 8 bases in Kwun Tong are shown in Figure 4.9. As Kwun Tong has grown, new bases have been set up, maximizing the efficiency of nurse movements. Each base is responsible for its own small scale service area which is small enough to enable the nurse to travel from base to patient without spending an excessive time on movement. This enables the high number of home visits (6.5/nurse/day) compared with the MHD CNS load of 3.1 visits/nurse/day. This means of organization may be more costly in terms of rental and upkeep of bases,
but does result in high levels of use. All bases are still within easy reach of the hospital from which deliveries of drugs and sterile supplies can be effected each day. Having small patches/service areas, enables nurses to get to know areas well and to get to be known and this may help their role as educators and advisers. Regular contact with the nurses raises the hospital's profile in the service area. In principal, it might be possible for data collected by nurses in the field to be transmitted back to the hospital, although there is no evidence of this being done. Data collected relates to very basic activity data - issues of dependency and outcome are ignored.

In choosing bases and small scale service areas, there has been no suggestion of defining spatial communities. UCH CNS is very much a service-oriented agency trying to maximize its efficiency in a particular form of health care delivery. The sharing of premises with the Kwun Tong Community Health Project has been largely through convenience. Although a productive co-operation between the two should have been possible and desirable, some unfortunate tensions have arisen, and where it has been possible, the community nursing base has moved. Thus, one excellent opportunity for intersectoral collaboration has been lost.

In terms of location, the actual choice of site has been determined by both macro- and micro-scale factors. On the
macro-scale has been the desire to minimise the distances that nurses have to travel to make it possible to visit a complete day's caseload on foot. On the micro-scale, the availability of suitable or affordable premises has been the most important consideration. In some cases, as noted, premises have been shared with the Kwun Tong Community Health Project and in one case with a Government clinic. The high rentals in the Kwun Tong central area mean that the central base is located at the CNS headquarters at UCH itself. This increases journey times for nurses who must take public transport to the town centre.

As a deliverer of health care, community nursing, as exemplified by the UCH CNS agency, provides a high standard and valuable medical service, through which pressure is taken off hospital beds and through which much suffering can be alleviated. By bringing care into people's homes, patients and their families can be helped to cope and to come to terms with whatever problems they have encountered. They can be taught and there is scope for preventive health. This is seen in the selected case studies observed which are included at Appendix C.

As a subvented organization, UCH CNS has had to maintain standards within tight financial constraints. However, subvention has also limited what it can do. Subvention allows little scope for experimentation and UCH
CNS is under pressure to justify its more expensive nursing bases policy by maintaining high workloads. What can take place within the half hour visit is therefore determined by the initiative of the nurse. Initiative is a variable although it can be fostered by the ethos of an organization. In UCH CNS, there is some attempt at sharing of ideas and learning from experience each week when all staff meet at HQ for case conferences and seminars. UCH CNS nurses are possibly less constrained than their MHD counterparts, whose work is affected by strict bureaucratic regulation (MHD nurses are unable even to remit fees as this is deemed to be a job for a medical social worker). Even so, in terms of intersectoral collaboration, links forged may be weak. As Table 4.10 shows, the referrals are predominantly from UCH and other hospitals. The referrals from GPs (which include those in KTCHP health centres) are insignificant. Referrals by nurses to other agencies (home-help, care and attention homes, day hospitals) do occur but there is much to suggest that while the collaboration philosophy in Government may be weaker, MHD nurses have a better success in referrals, given MHD's preferential access to these other services (see 3.16). Table 4.11 reveals the referral histories of those patients visited on home visits as part of this research. These suggest that UCH departments are most important as referrers and that GPs, including those of the associated Kwun Tong Community Health Project (see 4.12), are making few referrals.
Table 4.10  Referrals to UCH CNS  
April 1986 - March 1987  
(Source: UCH statistics)

<table>
<thead>
<tr>
<th>Referral agency</th>
<th>No. referred</th>
<th>% total cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCH AED</td>
<td>369</td>
<td>9.5</td>
</tr>
<tr>
<td>UCH OPD</td>
<td>74</td>
<td>1.9</td>
</tr>
<tr>
<td>UCH obstetrics</td>
<td>2,268</td>
<td>58.0</td>
</tr>
<tr>
<td>UCH New born special care unit</td>
<td>191</td>
<td>3.3</td>
</tr>
<tr>
<td>UCH geriatrics</td>
<td>94</td>
<td>2.4</td>
</tr>
<tr>
<td>Other UCH departments</td>
<td>484</td>
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<tr>
<td>Government hospitals</td>
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<td>7.5</td>
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<tr>
<td>Subvented hospitals</td>
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<td>3.8</td>
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<tr>
<td>Private hospitals</td>
<td>17</td>
<td>0.4</td>
</tr>
<tr>
<td>CNS centres</td>
<td>16</td>
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<td>GPs</td>
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<td>0.4</td>
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<tr>
<td>Other</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,912</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Table 4.11 A sample of case referrals to UCH CNS

Of 31 cases interviewed on home visits:

1. Voluntary presentation UCH AED -> UCH -> UCH CNS (6)

2. Ambulance/police -> UCH AED -> UCH -> UCH CNS (1)
   Ambulance/police -> UCH AED -> UCH -> CNS and Day Hosp (1)
   Ambulance/police -> UCH AED -> UCH OPD -> UCH CNS (1)

3. UCH AED -> UCH OPD -> UCH CNS (2)

4. UCH OPD (O&G) -> UCH -> UCH CNS (6)

5. AED -> UCH OPD -> UCH -> HOH -> UCH CNS (1)

6. UCH AED (ambulance) -> UCH -> QMH -> UCH -> UCH CNS (1)

**Government referrals:** (single cases)

- NTKJCHC -> UCH OPD (M) -> UCH CNS
- KCRMCHC -> QEH -> UCH CNS
- KTJCHC(SL) -> UCH OPD -> UCH -> UCH CNS
- QMH AED (ambulance) -> QMH -> UCH CNS
- Home help -> CNS -> UCH OPD -> UCH -> UCH CNS

**Private referrals:** (single cases)

- GP -> AED -> UCH -> UCH CNS
- GP -> UCH OPD (M) -> QEH -> UCH CNS
- GP -> ADVENTIST -> UCH CNS

**Subvented referrals:** (single cases)

- CARITAS -> UCH CNS -> UCH AED -> UCH -> UCH CNS

**Kwun Tong Community Health Project referrals:** (single)

- Yau Tong -> UCH OPD -> UCH -> UCH CNS
- Sau Mau Ping -> UCH CNS

**KEY**

- AED: Accident and Emergency Department
- OPD: Outpatient Department
- O&G: Obstetrics & Gynaecology
- M: Medicine
- QMH: Queen Mary Hospital
- QEH: Queen Elizabeth Hospital
- KTJCHC: Kwun Tong Jockey Club Health Centre
- (SL): Shun Lee Estate satellite centre for KTJCHC
- KCRMCHC: Ko Chui Road Maternal & Child Health Centre
- NTKJCHC: Ngau Tau Kok Jockey Club Health Centre
- HOH: Haven of Hope
Apart from community nursing, the Kwun Tong Community Health Project represents the main thrust of attempts at intersectoral collaboration. The KTCHP has remained outside the subvented sector as a private non-profit agency relying on fees-for-service and grants from major donors abroad and in Hong Kong enabling it to experiment and to initiate programmes. It receives no direct Government funding. About 75% of its annual budget of £700,000 is income from fees. Currently, it operates 3 general health centres, an occupational health centre, 5 health maintenance programmes and is involved in health education programmes and ad hoc campaigns. KTCHP employs a staff of 70 including 4 GPs, 4 dentists, nurses, social workers, health educators, materials producers and administrative staff.

What follows is an account of the way in which the Kwun Tong Community Health Project has explored possibilities within UCH's service area and the extent to which it has contributed to the development of an interactive service area and to intersectoral collaboration. KTCHP was intended as a vehicle through which UCH would develop its relationship with its service area. The two organizations share similar philosophical origins. An early study paper produced in 1970 reflected the same interpretation of
health as in the UCH proposals. This study saw Kwun Tong very clearly as a unit. From a subjective outlook, it highlighted key community health issues of an environmental nature, including noise, pollution, overcrowding and poor recreational opportunities (KTCHP, 1970). The study acknowledged a low awareness of personal health suggesting that poverty with associated subclinical malnutrition was a problem. The study pointed out that industrial growth had proceeded in Kwun Tong without adequate consideration of health needs by planners, and this had resulted in a shortage of medical facilities (KTCHP, 1970).

The KTCHP planners believed from the outset that the most effective programme would be one rooted in a medical approach, in which the hospital would have a key role. A 5-pronged attack was proposed concentrating on:

a. the development of home nursing;
b. promotion of the family doctor concept;
c. the development of school health services;
d. the introduction of industrial health schemes;
e. health education.

Later on, other objectives, such as those related to community development, were added. From the beginning, the project was viewed as a hospital-backed initiative spearheading hospital outreach into the community around.
At this stage, the service area of the Kwun Tong District was seen as the "community". In view of the apparent immensity of the problem of service provision within Kwun Tong, it was hoped that the KTCHP would act to reduce pressure on the hospital through preventive health and a screening and rehabilitative outpatient role. The KTCHP would increase the profile of the hospital in the community, whilst the connection with the hospital was regarded as essential in establishing the KTCHP's credibility.
4.13 Stages in the development of the KTCHP

In reviewing its development, the KTCHP has identified four discrete stages (Lo et al, 1985) -

1. 1972-1975 - "exploration of the concept of community health and setting up medical extension programmes as an entry point";

2. 1976-1979 - the establishment of health maintenance programmes and community development initiatives;

3. 1980-1982 - "reformulation, integration and consolidation";

4. 1982 onwards - "dissemination and replication".

These stages are elaborated below using information gleaned from interviews with eight past and present key personnel, publicity materials, a sympathetic analysis (Lo, et al, op.cit.) an officially commissioned evaluation study (KTCHP, 1979), academic studies by KTCHP GPs (Lund, 1980; Tong 1985), this author's own utilization study (Paterson, 1977 op.cit.) more the critical analyses offered by Rifkin (1985, op.cit.) and McDermott (op.cit.).

Phase 1 - 1972-1975

In the initial phase, priority was given to the establishment of facilities and medical services for several reasons -
a. there was a clear, unmet need for medical services in the new housing estates;

b. despite the cost implications, facility provision is relatively straightforward and is an effective way of getting things started;

c. it was felt to be important for the community to be able to see tangible investments being made on their behalf;

d. donors were prepared to fund such developments;

e. KTCHP was one of the agencies experimenting with home nursing at this time and it was important to have bases strategically placed in the service area from which to operate;

f. a base in the community could provide the information feedback to the hospital as to the nature of disease and health needs of the community.

The first health centre was opened by KTCHP in Sau Mau Ping Estate in 1972 (Figure 4.9) over a year before the opening of the hospital. This area was chosen because of its proximity to the hospital and on the micro-scale, because of the availability of space in the estate welfare block. It is significant that on completion of the hospital premises, KTCHP moved its administrative offices from the Sau Mau Ping centre to the hospital where they have remained.
The Sau Mau Ping Centre was followed by similar units at Lam Tin Estate and Yau Tong Estate both in premises allocated by the Housing Authority. In 1976, an Occupational Health Centre was established as near to the industrial area as was possible in private commercial premises. The four centres are therefore dispersed across the Kwun Tong area reflecting a desire to influence the Kwun Tong Community at large rather than to concentrate on one particular section or area. Although the Occupational Health Centre has changed its location to a nearby street, there have been no new health centres since. By themselves, health centres will not necessarily contribute to the development of community health or to the promotion of intersectoral collaboration. Much will depend on the way they are operated and how they respond to needs as expressed in the communities they are supposed to serve.

4.14 Phase 2 – 1976-1979

In Phase 2, a big attempt was made to direct the activities of the health centres to health promotion, to changing the relationship between client and provider and in involving the community. In 1976, the KTCHP received funding from the West German Protestant Central Agency for Development Aid – the organization that had provided much of the capital cost of United Christian Hospital – to establish health maintenance programmes and to initiate a community development programme.
The Health Maintenance Programmes (HMP) were supposed to become self-supporting by the end of the subsidised period of 3 years when, under the terms of the grant, the Project would be independently evaluated. In an HMP, an individual pays a subscription which entitles him/her to an initial check-up, periodic checks, information and support and some discount on services from the centre. There were three main objectives -

a. to aim mainly at high-risk target groups - infants, school children, factory workers and the elderly;

b. to encourage a more consistent use of GPs against the Hong Kong norm of minimal doctor loyalty;

c. to act as vehicles for health education and screening.

These were an innovation to Hong Kong as was the use of "nurse physician assistants" on each of the HMPs. These were nurses trained under an experimental scheme at UCH to handle routine tasks of doctors with the long-term goal of relieving pressures in the UCH AED, caused by people presenting with minor ailments. However, the scheme ran into serious professional obstruction and legal complications and floundered.

Another interesting development was the targeting of individuals and groups within the service area an important feature of an effective outreach of a hospital. Targetting is also of fundamental importance for health
education. In retrospect, this is also interesting as it shows that even at this early stage, sight was being lost of the spatial community. At-risk groups meeting together, as in old peoples' clubs, cholostomy clubs and so on, would themselves be operating as communities, despite coming from different parts of the service area.

The Community Development part of this phase involved a conscious attempt to encourage public participation. The exact objectives were not altogether clear however. Some KTCHP workers felt that the ultimate goal should be the handing over of control for health centre and programmes to the communities they served. Others aspired to simply increasing the levels of participation in health programmes. This divergence of opinion was to create considerable tensions in the following years.

Initially, whatever the objectives were thought be, it was clear that readily defineable communal groups and organizations, which were needed in the areas around the health centres, were largely absent. It was thus felt that "community development" was a priority. To this end, community development workers were added to the health centre teams. This represented an important shift in attention from the large scale service area to a much smaller scale determined by the community envisaged. This gave licence to a whole range of scales being considered - the factory, the housing block and even the block corridor scale.
To start with the community development workers concentrated on three groups of potential participants -

a. volunteers, often those who were ex-hospital patients, friends or relatives of patients;

b. members of existing community organizations, in particular the Mutual Aid Committees (MACs) of the housing estate blocks (set up by the Government in the early 1970s as part of an anti-crime drive);

c. members of a particular target group such as the elderly, mothers of infants, or in the case of occupational health, groups of factory workers.

Of these groups, often only the MACs were spatially defined.

Two modes of participation were attempted. In the first, the community development worker helped the MAC to form a Peoples' Health Advisory Committee with the eventual, if never realised, aim of the committee running the health centre (there were major differences of opinion on what powers would be delegated to the committee). The committee was supposed to oversee a training scheme for community health workers known as Health Advocates. These were volunteers, not selected by the community, who, after training, were expected to assume the roles of advisers, confidantes and health promoters amongst their neighbours in the housing blocks.
Commentators have been critical of the way in which these committees were run. McDermott (op. cit.) for instance, has criticized the way in which the community development workers failed to seize problems brought up by the committee members, such as environmental and working conditions, and even the political situation, as issues to "organize around or to act against" (p.197).

In the second mode of participation attempted, community residents were encouraged to join health education, community activities and other promotional campaigns. This is something which has continued and which KTCHP seems to excel at, although an evaluation of the actual effectiveness of such activities and campaigns is hard to make.

The KTCHP's experience in Community Development has been examined in detail by Rifkin (1985 op. cit.) as one of 3 case studies of Community Development-style health care initiatives in Asia. As has been seen in the discussion of her model in Chapter 1, Rifkin is concerned with the importance of professional medical personnel and the comparative roles of service provision and health promotion activity.

Rifkin's case study of KTCHP must be treated with care. Although in her foreword, she states that the book does
not condemn but rather is "a salute to the courage and commitment to those who moved outside traditional health care delivery systems and sought to rectify its obstructions and injustices", (p. xi), she has little, if anything, positive to say about KTCHP. This contrasts sharply with her other case studies which give less attention to specific detail. While she notifies the reader of her membership of the Management Committee of KTCHP for 5 years and that she was "engaged in the dialogue about community participation at this crucial period" (p. xv), she does not elaborate on whether she actually played a part in a "movement to remove the Project completely from hospital jurisdiction and re-establish it in the community with a much stronger emphasis on community involvement" (p.79).

Rifkin argues that the problems faced by KTCHP in its community development initiative stemmed from its orientation to medical professionalism. The "elevated position for the role of health services" meant that "community development was relegated to the realm of rhetoric" (p.77). According to her account, there was confusion over the planners' intentions and the implications of community development to the future of the whole programme were inadequately discussed. They "could neither conceive nor articulate the objectives of community participation with the same clarity that they
stated the objectives of providing health services" (p.78). Community development was "grafted" on to the service oriented project and there were serious "graft acceptance" problems.

Rifkin concludes that this led to a "direct confrontation between those who only accepted the theory and those who sought its practice" (p.79). Whether it was as simple as this is debateable. What is clear is that this period was one of considerable trauma for the KTCHP resulting in a great deal of uncertainty and a threat to morale. Some disaffected staff left, some to establish alternative modes of Community Health elsewhere.

Evaluating the Kwun Tong Community Health Project

The evaluation exercise that was required by the German donor took place in May 1979. Two evaluators (from the Institute of Development Studies, University of Sussex and the Christian Medical Commission, World Council of Churches) visited KTCHP, producing a short report for internal circulation (KTCHP, 1979 op. cit.)

This report spoke favourably of the GP services at the Health Centres, noting that these fulfilled a real need and were a clear response to "the expressed wish of the community". In contrast, the report was unimpressed of the dental care offered which could be regarded as "no
more than an average approach" that "did not seem to reflect an imaginative attitude to community dental needs" (p.3). The evaluators regarded the fee structure as "well within the reach of the residents".

The relationship between health centres and UCH was described as "positive and productive" (p. 2) and both the Community Nursing Service (although since subvention, no longer a part of KTCHP) and the School Health Scheme were applauded as examples of the interplay possible between a non-government organization and Government service. The evaluation team found the Health Maintenance Programmes difficult to assess so early in their existence, but nevertheless raised pertinent questions as to:

a. the extent that they were designed to meet priority needs in the community;

b. the extent they overlapped Government programmes;

c. and their cost effectiveness.

In general, the evaluators seemed impressed with the innovative nature of the KTCHP. However, they warned that the KTCHP could not remain forever on the fringe. The advantages of innovation and experimentation had to be weighed against the advantages of integration into the overall health service. This was regarded as being important from a service point of view as well as being of
financial significance. It was important for KTCHP to think carefully about long-term financial planning. Overseas aid could only be relied on to see a project through its early phases. Local sources of funding had to be identified, moves had to be made towards obtaining Government subvention. The evaluators had found that -

"...financial pressures can change the very nature of the programmes, moving them "upstream". More extensive, expensive and sophisticated programmes may be, or may be thought to be, more saleable and hence more capable of being self-supporting. Programmes can thus move away from providing for the most widespread and basic needs of the community" (ibid p.5).

The last part of the evaluation attempted to tackle the relationship between the KTCHP and the community it was working with and reflected some of Rifkin's concerns. The evaluators felt that "the staff have clearly been viewed as people who do things for and provide services, to the community" which had a "very peripheral role", concluding that the "(p)roject functions from the top down in virtually every aspect of activity" (ibid p.6).

The report acknowledged the considerable confusion over the nature of community development. Open and concealed conflicts led to insecurity amongst the staff which was manifested in an intolerance of authority and aggravated by personality clashes. These problems had been communicated to members of the public involved in the Project. The evaluators argued for a return to basic concepts and objectives.
In overall terms, the evaluators saw a clear distinction between health service provision and community health. Suggesting that the link with the hospital made community health and development programmes difficult, they argued that it might be better to separate health services from community work. The initiation of a "true community primary health project" required the formation of a new separate organization which would —

".... be built upon the concept of full participation by the community with a small team whose basic function is to motivate, mobilize and stimulate the community and assist the community in understanding the wider range of alternatives available to it and in deciding what it can do itself" (ibid, p.8).

With hindsight, it is possible that there were more reasons for KTCHP's apparent failure in community development than those suggested by the evaluating team and Rifkin. It is necessary to examine critically the very concept of "community development" which is based on tenuous assumptions that —

a. community development is possible and potentially popular in an individualistic modern world;

b. communities are actually sceptical of the value of modern medicine and the services provided by medical professionals;

c. communities have any desire to make decisions regarding health needs and services required;

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d. communities are capable of (or can realistically be trained to be) assessing health care needs in any situation other than the poorest environmental and social conditions;

e. communities can agree on priorities in situations where choices are available and differential access is prevalent.

Community development may have potential in places where environmental and disease problems are clear cut (such as in the stereotype Third World urban slum with no sewage and with no water supply), where poverty reduces all participants to a similar level, where choices, if available, are outside the reach of the people, and where co-operation and compromise are seen to be essential for survival. Nowhere in the Kwun Tong service area do such conditions prevail.

It is interesting, at this point, to refer to the experience of one alternative Community Health project established in Chai Wan on Hong Kong Island. This took the form of education and self-help schemes for groups such as factory workers. No attempt was made to become involved in service provision, the emphasis being on raising consciousness and confidence, and through this, to strengthen the community. It is interesting that those involved became prominent members of the Eastern District Hospital Coalition (see 3.14). When asked to "decide" on
service provision (in line with ideas on community development), this particular community could see priorities only in terms of the most sophisticated level of hospital care, requiring vast resources, to be provided by Government, and to be completely outside their control.

4.15 Phase 3 (1980-1982) and Phase 4 (from 1983)

Phase 3 saw the KTCHP trying to sort itself out in the aftermath of the rows over community development and the official evaluation. Moves to separate the medical aspects from the health promotional aspects, as suggested by the evaluation team, were quashed. The community development initiatives were largely abandoned and the workers explored new directions, either in health promotional activities or by working with specific target groups such as the elderly, the mentally ill or inhabitants of a large squatter settlement who were mostly recent migrants.

With the exception of the last group, the KTCHP has seemed to move away from notions of spatially defined communities. In this and the succeeding Phase 4 ("dissemination and replication"), KTCHP activities, apart from the services at health centres, have often taken on a District level perspective and increasingly a Territory-wide one.
Before a conclusion can be reached regarding the connection between KTCHP and the hospital service area, and the extent to which KTCHP can or should be replicated (as is the intention in Phase 4), it is necessary to examine the current range of services and activities.

The 3 estate health centres have continued to operate popular GP and dental services. Charges are generally below those in local private practice although significantly more than those charged in the Government clinics in the Kwun Tong area (a visit to a KTCHP GP would cost £4-5 including medicine for 4 days). The estate centres are located in Housing Authority premises (which dictates the micro-scale locations) rented on favourable terms. The Occupational Health Centre is in commercial premises and the high rental is reflected in slightly higher service charges. UCH CNS uses two of the health centres as bases (see Figure 4.9).

Summaries of medical data of patients attending KTCHP health centres is sent to KTCHP Head Quarters on a monthly basis, but little use has been made of this. There has been a paucity of work on general morbidity patterns in Hong Kong but the KTCHP data do reflect the survey findings of the Hong Kong College of General Practitioners. Lund's (op.cit.) study of his work as GP at Yau Tong Health Centre and Tong's (op.cit.) study of her
work as GP at Lam Tin Health Centre plus other KTCHP data show respiratory diseases account for 50-65% of attendance, gastro-intestinal diseases accounting for another 8-12%, and dermatological complaints accounting for 6-10%. Further comparison is difficult as these categories are seasonally affected. Comparison on a geographical basis has also not been very informative. The KTCHP data does apparently reflect a known tendency for public housing estate residents to suffer more from colds and for those living in East Kowloon to suffer slightly more colds than those elsewhere in Hong Kong (Tong, op.cit).

There is a tendency for utilization of the health centres to be by people living within the estate although this is by no means exclusively the case as might be expected with "doctor shopping". Lund found that 40% of his patients came from Yau Tong Estate itself while another 40% came from Ko Chiu Road Estate nearby. Some 12% gave addresses outside Kwun Tong District. It is possible that these may have been working in Kwun Tong or visiting relatives at Yau Tong. In a study of utilization at Yau Tong conducted in 1976 (Paterson, 1977 op.cit.), no real distance decay could be detected amongst those giving Yau Tong addresses although attendance of the health centre by residents in Block 23, in which the health centre is located, was highest. When hospital attendance rates for the individual blocks at Yau Tong was assessed, it was also found that
Block 23 had the highest rate of inpatient attendance although in general there seemed no correlation between Health Centre attendance and attendance at UCH. Physical access to the Yau Tong Health Centre is good for residents of both Yau Tong and Ko Chiu Road estates. The health centre fronts onto stalls in the market in Yau Tong.

Lund (op.cit.) reported referring 5% of patients to either specialist departments or AED at UCH. Noting that this compared with 2.9% in a comparable Government survey, he observed that many came to the health centre specifically for referral, which in many cases was justified. All cases for minor injuries were referred to UCH AED, as although equipped to carry out minor surgery, time restraints prevented this. Lund reckoned that such cases would not have attended an MHD clinic but would have instead presented at the hospital directly. Lund's experience at Yau Tong is reflected in the other health centres. A survey of referrals at Sau Mau Ping Health Centre in 1983 put the referral rate as low as 2.1% (personal communication). The survey of specialist out patient referrals at UCH in December 1987 conducted as part of this current research (Table 4.3) shows that the KTCHP centres are not referring large numbers of patients directly to specialists. KTCHP GPs can refer patients to hospitals other than UCH when waiting lists for outpatient appointments are too long (defined by one KTCHP GP as

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"over 1 month").

In terms of the original objective of promoting the family doctor concept (see 4.12), the KTCHP health centres do maintain a high standard of record keeping and have experimented with patient-held transferrable records to at least alleviate the problems caused by doctor shopping. On an individual basis, doctors may keep records of members of specific target groups they encounter such as smokers, those with hypertension or diabetes, with a view to contacting them for health promotion activities or reminders. This ad hoc collection of data seems to be unco-ordinated.

Patients do return to the health centres on their own accord. In this author's 1976 survey at Yau Tong (Paterson, 1977 op.cit.), it was found that 57% of those on record had returned at least once in the ensuing year, indicating a degree of patient satisfaction and doctor loyalty. There was no means of telling how many other GPs they had visited in that period.

Lately, there has been a specific attempt to try and use the health centres to relieve the OPD load at UCH by referring patients with on-going, non-complex requirements (e.g. regular checks, medication) to health centres rather than having to queue and wait at the hospital. This presents advantages for the patient but because this is a
non-subsidised service, the patient must pay much more than would be charged at specialist OPD and has met with mixed patient reactions.

The combination of services at one location has helped to effect some integration of services. The centres have become very important bases for health education and for certain groups (the elderly) involved in special programmes, they have become important social and welfare centres as well. The range of activities at Sau Mau Ping was such that at one time, it spilled over into 3 different sites. One aspect of the health centres impressive to the visitor is the role of the volunteer. These include those actually participating on the programmes such as the Geriatric Health Maintenance Programme such as the elderly man responsible for reading the blood pressures, as well as students and others.

The HMPs continue though they still rely on funding from external sources and show no prospect of becoming self-sufficient. For those aged less than 1 year, the Infant HMP in fact replicates the Government's Maternal and Child Health scheme which is available at much lower cost. However, beyond the age of 1, there is no Government alternative and the scheme with its appointment system (as opposed to queueing) and a satisfaction from clients still attracts some 2000 subscribers.

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The Occupational HMP has met with only very limited success partly because of employment traditions in Hong Kong. Workers are highly mobile between jobs and sectors and this is exacerbated by recent labour shortages. Most employers give workers a sum of money to attend a clinic if ill and workers prefer the choice this affords. Even when an employer has a permanent arrangement with a particular GP (as they might under the HMP), employees may demand alternatives. Consequently, the occupational health package offered by KTCHP, which was intended to give access to factories and to help in the monitoring of occupational diseases, has been unable to fulfil its objectives. Only 4 factories have adopted the whole package, although KTCHP has links with 40 other factories. There are, however, over 3000 factories in Kwun Tong.

The school programme is an adaptation of the established School Medical Service whereby Government gives an allocation to a doctor for each child registering, in return for reduced attendance fees. The KTCHP has made use of this to register children on the condition that the whole school registers with the health centre. In return, the health centre waives fees altogether, gives the school health education support, and conducts mass screening, none of which would be provided by a private GP. This has provided an indirect subsidy to KTCHP, whilst providing excellent access to a captive target group. It has
however, been very unpopular with local private GPs who campaigned unsuccessfully to have it stopped. The forging of good relations with private sector GPs has never been an objective of KTCHP, a point that will be returned to below.

The Geriatric HMP has assumed a much wider role than simply giving medical care. It would seem that, for many, the main attraction is the social aspect of the regular meetings in the health centre for the Geriatric clubs. This is, despite its popularity and apparent success, the least likely of all the programmes to become self-supporting. In an attempt to keep numbers up, old people are bussed in to the Sau Mau Ping centre from outside the Kwun Tong area from institutions as far away as Sheung Shui and Tuen Mun in the New Territories. This is an example of how KTCHP has moved away from its District-level perspective.

Community development workers have been involved in the various programmes such as a Community Mental Health programme based at Sau Mau Ping which has attempted to organize activities for those with a mental illness history. In Hong Kong, there are major shortcomings in post-discharge care and a paucity of half-way houses. There is no official Community Nursing for Psychiatric patients although UCH CNS may visit some cases. There is also a pressing need to prepare the general public for
receiving the mentally ill back into society. In Kwun Tong, murder cases involving ex-patients have strengthened prejudices. The strategy for such a programme has to include this general education as well as activities for target groups. The spatial areas involved may be indistinct. Indeed, this is increasingly the case for all the programmes. There has been a tendency to base particular programmes at one of the health centres, further evidence of the decreasing importance of the spatial community.

In recent years, the highest profile activities organized by KTCHP have been its health promotion campaigns and ad hoc activities. KTCHP is able to involve large numbers of people as volunteers for campaigns. KTCHP was one of the first organizations involved in anti-smoking drives and is now a major contributor to activities of the Smoking and Health Council and an active promoter of the annual "Smoke-Out Day". It is the only hospital connected organization involved in major Chinese language anti-smoking campaigns.

Many of the campaigns have been directed at the Kwun Tong District. KTCHP initiated a Kwun Tong Mental Health Education Group which meets bimonthly and includes representatives from mental health organizations, schools, UCH, District Board and the Society for the Aged. In the
case of its Elderly Health Campaign, KTCHP made use of an already existing body, the Kwun Tong Elderly Co-ordinating Committee. In its Sex Awareness project, KTCHP worked closely in the initial stages with school principals from Kwun Tong. Indeed the programme was a response to a request from Kwun Tong schools.

However, increasingly, it has become involved in projects not just throughout Hong Kong such as the Lions Club-financed Diabetes Campaign, but along with UCH has even been involved in projects in China. It seems to be widely respected as an organization with good health education ideas, which despite very limited resources, is able to mount impressive and attractive public displays. Materials are loaned to organizations throughout Hong Kong, and the only restriction to this is that a small charge is made to non-Kwun Tong bodies.

These campaign activities have broadened the role of KTCHP from the local block level to the District-wide level and beyond. Whilst they incite a positive response, they remain difficult to evaluate and because they have not been evaluated (beyond simplistic measures of attendance etc.) it is difficult to assess their potential or to justify their replication. They may also have detracted from other activities of the KTCHP and at times, overstretched limited resources. The current phase of
KTCHP is supposed to be one of replication, but this is not happening. At the same time, KTCHP has reached a crisis in its own funding as traditional donors lose interest. In its 18 years of existence, KTCHP has failed to interest the Government — indeed there is little evidence that it has tried to — and there is currently no immediate prospect of Government subsidy.

Many of the problems faced by KTCHP are those of a pioneering organization working against a prevailing philosophy and pioneering ideas that may be ill-developed elsewhere in the world. KTCHP has, over the past 18 years, explored the service area of Kwun Tong. In its failure to find identifiable spatial communities on large and small scales, it has ended up operating on a wide variety of scales both within and outside what the hospital has perceived as its service area.

4.16 Other activities of UCMS

Over the years, the apparent failure of KTCHP to relieve load on the hospital, especially the AED, plus a general disappointment in other aspects, have led to additional activities and services being provided outside the realm of KTCHP.

Firstly, a "community clinic" has been established at UCH itself, operating in working hours on a non-appointment
basis to draw non-emergency cases away from AED. Nurses in AED may also screen clients and send them to the community clinic. This clinic is doing what was originally envisaged as one of the KTCHP's health centres' functions.

Secondly, the failure to develop identifiable communities has led to a revival of interest in the family as a unit with which health promotion can be effected. In the Nethersole School of Nursing, which is part of UCMS, a family advocate scheme has been introduced which involves student nurses being attached to a particular family in the Kwun Tong area. The student nurse visits on a regular basis with the idea of acting as a bridge between hospital and family, learning from the encounter and helping to give advice to the family.

Thirdly, a range of programmes organized by the UCH chaplaincy team operates independently of KTCHP and its outposts. The team's role is not intended to be evangelical, but to provide pastoral care for patients and relatives; to offer staff counselling; to provide training in issues of caring and counselling; and to develop links between hospital and churches. It is also closely involved with the UCH hospice unit.

In their training programmes they have involved both people from Kwun Tong organizations and from throughout Hong Kong. In the early days, the links with churches were
important from a funding point of view, for the recruitment of volunteers and to try and defuse demands from church members for preferential admission to UCH. Of these functions, it is the recruitment of volunteers that remains the most important. These links are not necessarily with Kwun Tong churches. Volunteers may come from churches all over Hong Kong, and this will account for some of the movements into Kwun Tong of volunteers already discussed, although by no means all volunteers are church people (4.5). While the chaplaincy's outlook is ecumenical, there are many churches in Kwun Tong of an evangelical nature which are not interested in community service or in any contact with UCH. Despite its Protestant origins, UCH has had productive relations with Kwun Tong Catholics.

In recent years, church volunteers have been recruited in an expansion of the chaplains' pastoral role especially for their "Good Neighbour" scheme which has been run independently of KTCHP neighbour schemes. One aspect of this scheme involves visiting former patients at home, targeting people in particular need, such as those who have been suicidal or those who feel isolated. This scheme has no service area boundaries and those doing the visiting may come from anywhere. However, at the chaplaincy's Good Neighbour Centre in Sau Mau Ping, two social workers organize group activities and support
services for discharged psychiatric patients, largely from the Sau Mau Ping estate.

All three additional developments discussed above recognize the existence of people as individuals, not necessarily as part of a spatial community. Neither is the caring community, a spatially defined entity. While these projects clearly attempt to tackle particular needs, they add to the confusion of what community health care really entails for UCMS and the people of Kwun Tong. As a result, the various components of UCMS now operate over a wide variety of scales.

A simple classificatory scheme is proposed in Figure 4.12 in which the "spatial spread" of the main services and activities within UCMS is represented. These are first classified according to approach adopted - the degree to which provision is made indiscriminately or with specific people in mind. The "blanket" approach, for example, is offered to all within an area. Other services or activities are "targetted" at individuals or groups sharing certain characteristics, an important approach for advocates of community health.

The area served, or the area from which those utilizing a service or affected by the service are located, is then considered. This "spatial area involved" is classified according to extent. The "patch" has been defined as "a
Figure 4.12: Classification of the spatial spread of activities and services of UCMS

<table>
<thead>
<tr>
<th>Services offered for all within area</th>
<th>Named individuals are referred for service or sought out for attention</th>
<th>Provision is made for specific groups usually those groups &quot;at risk&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BLANKET APPROACH</strong></td>
<td><strong>TARGETING INDIVIDUALS</strong></td>
<td><strong>TARGETING GROUPS</strong></td>
</tr>
<tr>
<td>Maximum extent of UCH service area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TERRITORY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>REGION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DISTRICT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLOCK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATCH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAMILY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**UCCH**

- **AD**
- **COMMUNITY CLINIC**
- **OBSTETRICS**
- **GP**s
- **DENTISTS**
- **HEALTH EDUCATION**
- **DIABETES CAMPAIGN**
- **SCHOOL HEALTH**
- **INFANT HEALTH MAINTENANCE**
- **ADULT HEALTH MAINTENANCE**
- **CHAIRPERSON CENTER**
natural unit ... of up to 3000 people/500 families in well-defined geographical areas" (Hardie, 1985, p3). The "block" corresponds to the type of area that would form a "street block" in the Hong Kong Census. The "district" is the District of Kwun Tong, the declared service area of UCH and originally of KTCHP. The "region" is the hospital region in which UCH is located and the "territory" is the "national" area, that is the whole of Hong Kong. A measure of the area from which people involved in or affected by a service or activity is indicated by an arrow. Some distinction is made between what the activity consciously intends the spread to be (the "official" spread) and what the spread in reality is (the "unofficial overspill").

Some care in interpretation is needed, given that the "spatial areas involved" represent a "nested hierarchy" in which patches make up blocks and blocks make up the district and so on. The impression given is that UCMS operates over a wide variety of scales with little correlation between activities. Even activities within the same approach do not appear to have similar spatial spread characteristics.

There are further considerations to be made with regard to the nested hierarchies of spatial communities. As Figure 4.13 postulates, with increasing size of spatial area involved, the ability to act on environmental and personal health issues may vary, but this is highly dependent on
Figure 4.13 Possible implications of a nested hierarchy of spatial communities
the nature of political organization at each level. With each increasing size of spatial area involved, the greater threshold in economic terms enables a higher order of facility or service to be provided and this is crucial in service provision considerations. If spatial communities are too small to enable service of a particular order to be provided then they cannot be used as the basis of that service provision.

As far as the KTCHP is concerned, it would appear that over the years, a spatial definition of community has been elusive and that to some extent, activities have lost sight of the intended service area. In the case of hospital services (with the exception of obstetric care), the service area boundary has continued to be permeable, something that may ultimately be outside the hospital’s control.

In Chapter 1, a classification of community health projects according to Rifkin (1985, op. cit), was discussed and the types of approaches she identified were re-interpreted as spatial models (Figures 1.5.1-3). To which model might the activities and services of UCMS correspond? In Kwun Tong, there are very many competing service providers who make intersectoral collaboration harder. These competing service providers include the MHD itself, which does not work effectively with the subvented UCH. The health authority, in this case the MHD, is
external to the Kwun Tong area. Nominally, it is located in its regional base, but in political reality, its power base is highly centralized. Since the hospital's funding comes in the main from MHD and since MHD only allocates funding for community nursing, the hospital is not responsible for much resource transfer to its outposts. The KTCHP outposts receive outside funding independently. There is, however, overlap in the management of KTCHP and UCH and so in the end, medical professionals at UCH have played a part in the decision-making of KTCHP. The KTCHP headquarters are geographically part of the hospital campus. There has, particularly in the past, been some professional support transfer between UCH and KTCHP, but there remain low levels of referral from KTCHP to UCH and from UCH to KTCHP.

The KTCHP has given recognition to local residents as service extenders (which is what most of the volunteer work does), and perhaps not so much as agents for change and it may be that the mechanisms needed to facilitate change do not exist. In locational terms, KTCHP has assumed that the potential for community involvement and community development was ubiquitous, instead of attempting to seek out places where that potential might have been stronger. The existence of target groups has been important to the work of KTCHP, but their spatial location has not been an influential consideration. This
has become even less so as KTCHP has seemed to expand its remit to beyond the Kwun Tong boundaries. The location of the hospital was a major consideration initially and, as has been seen, within the constraints imposed, choice was available and choice was carefully assessed, partly to maximize physical accessibility. The aim of locating the outposts has been to maximize service impact and this is seen particularly in the locating of the 8 CNS bases.

In term's of Rifkin's classifications, UCMS has apparently failed to develop fully a "health planning approach" although it has made some moves towards this. There are several contributory factors -

a. it has not been possible for an independent organization such as KTCHP to tackle pressing environmental problems;

b. the existence of so many competing service providers has made collaboration difficult. The KTCHP outpost co-ordinates only a few of the services available to the general public. KTCHP has made no attempt to involve local GPs and other organizations. It has failed to co-operate effectively even with other UCMS services such as CNS and the various programmes mentioned above;

c. the role of the official health authority, the MHD, is confused as it seems to aid competition by running its clinic and polyclinic services independently of UCMS.
4.17 Conclusion

It would seem that UCMS has succeeded in developing an approach somewhere between the strictly "medical approach" and the "health planning approach" but given the circumstances, it is unlikely that a further move towards health planning by the organization working in isolation is possible. Over its 18 years of existence, UCMS has pioneered many directions in community health care and promotion. In this, the organizations have proved to be a valuable think-tank of ideas and innovation. UCMS appears to have provided a high standard of service to clients and a useful backup service to many other agencies, especially in terms of health education and campaigning. It has, however, floundered in a number of important fields -

a. in effective intersectoral collaboration;

b. in producing a working definition of what community health care is and a spatial definition of community;

c. in producing convincing cases for replication for most of its innovative activity.

The time has now come for a major reappraisal of UCMS and community health. This is partly precipitated by a major financial crisis within KTCHP as funding persistently fails to match the level of service that it tries to provide and with no prospect of Government subvention, perhaps largely because it has made no real attempt to
seek it.

The time is also highly pertinent as major developments in the organization of hospital care are promised in the post-1990 establishment of a Hong Kong Hospital Authority. Chapter 5 looks at these developments and relates these to the prevailing hospital philosophy. It examines the potential for changing that philosophy and the role of organizations, such as UCMS, as instigators of change.
Mounting pressure from within and outside the hospital system has forced the Government to review hospital services and to reconsider plans for the future. Characteristically, as would be expected from the discussion in Chapter 2, this has not really led to a review of policy direction so much as a review of organization. If the Government is unwilling to examine policy in depth, it is unlikely that it is prepared to consider critically, the philosophy of hospital care that prevails in its hospitals.

This chapter examines the major review of hospital services conducted in 1985 and the consequent changes to be introduced in 1990. The proposals of the Review are linked to aspects of "prevailing philosophy" already identified in Chapter 2. The extent to which a change in spatial relationships and the medically dominant centripetal approach (discussed in Chapter 1) is likely, is assessed.

The failure of the review of hospital services to confront the major questions of philosophical stance can be linked to the constraints that exist within the system. This is not to say necessarily that the constraints are over-powering and that there does not still exist the possibility for change. The need remains for a move away from the notion that the only solution is more hospital care of the type fostered by the prevailing philosophy. This is emphasised by the current circumstances of flux, of which emigration of skilled professionals is now the most threatening. Because of this, not even all of the hospitals that have been built, to say nothing of the others in planning or construction, are able to function.
5.1 The Consultancy Review of Hospital Services

In February 1985, in response to repeated public and professional complaint, the Hong Kong Government appointed an Australian consultancy firm, W.D. Scott and Partners (a firm linked to management consultants Cooper and Lybrand), to review the provision of hospital services in Hong Kong. The use of external consultancy groups is now a well established procedure in the Hong Kong Government. It is not immediately popular with a public which questions the high cost and is suspicious of foreign experts finding out things which are already "obvious". Such consultancies may enable the Government to claim that it is approaching an issue seriously whilst deferring decision-making and absolving itself of responsibility for mistakes, even when, as Hong Kong experience has shown, it adopts recommendations only in part and often in diluted forms. In terms of activities at the "interface" between Government and Chinese Society (Chapter 2), an external consultancy can maintain Government "face" whilst enabling public criticism.

Past consultancies, particularly the McKinsey firm which reviewed Government administration in 1973, have been criticised for being so removed from the socio-political environment as to make their findings unworkable or irrelevant. Harris (op. cit.) has argued that like the Fulton Report in the UK, McKinsey began with the premise
that efficiency is gained by tinkering with the process. In other words, it was a purely mechanical exercise.

The Scott team worked hard to allay public and professional suspicions. They adopted an uncharacteristically open approach and certainly gave this researcher in interview, an impression of being well informed, clearly motivated and supportive of good practice. They had to work hard too at cultivating their political watchdog, an appointed Steering Committee which included participants in the present system whose management structures the review has effectively condemned.

However, they were unable (arguably through no fault of their own) to set the problems of hospital care fully in context both socially and in terms of the rest of health care services in Hong Kong. In this, there is little difference to earlier Hong Kong experience. In his critique of the McKinsey consultancy, Harris has asserted that this consultancy's findings implied that "the managerial horse pulls the sociological cart, that reason can prevail over passions and that cultural factors (i.e. the "Chinese Way") are not worth the mention" (op cit, p. 117) — he laments the fact that the word "Chinese" does not appear once in the main report. As a consequence little can be expected to change. Several years after McKinsey.
"Hong Kong is still what is has always been, an administrative state, distinctly anachronistic........ Officials have in some cases had new titles, offices have been physically reorganized and the Finance Branch has gone into open plan seating" (Harris, op.cit. p.116).

Perhaps the same can be expected of the Scott Review (henceforth referred to as the Review). Forced by its terms of reference, the team had to treat hospitals in isolation (UCH, 1985a). The remit concentrated on organizational structures (both of hospitals in general and internally); the imbalance between subvented and Government hospitals; more effective use of resources and cost control; overcrowding; staffing and working environments; hospital charges and better accommodation especially for those able to pay; and alternative funding methods including insurance. The Review, therefore, is of hospital services only. The consultancy team were unable to comment on vital relevant factors outside. The link between hospitals and Primary Health Care or any other aspects of intersectoral collaboration were ignored, as was even the role of Community Nursing Services, which was particularly disappointing given the experience elsewhere in the world that suggests home nursing can have a considerable impact on hospital bed use.

The Review was completed in late 1985 but the Government dragged its heels and did not published the report for public consultation until March 1986 (HK Govt., 1986a, op.cit.). This report led to a measure of public
discussion, being the subject of no less than 35 newspaper editorials. A formal period of public consultation closed in September 1986. The Health and Welfare Branch of the Government Secretariat edited and published a "Summary of Public Opinion" in March 1987 (H.K. Govt., 1987f). This set out to summarise the views contained in 99 written presentations, including 28 from civil service staff groups and 20 from staff groups and management of subvented hospitals. Representations from staff groups were by far the most vocal and reflected considerable fear that the terms of employment of Government health care workers would be adversely affected, rather than consideration of the medical or health consequences of the proposals. Indeed, it is fair to say that staff representations overshadowed serious discussion of other issues. Representations from subvented hospitals voiced concern over their future status and role.

Since 1987, the Government has taken its time to decide on the way forward. There have clearly been considerable fears within Government, in particular within the Finance Branch, of the financial implications, on which the Review was notoriously weak. Details of Government intentions trickled out to the press between late 1987 and December 1988 when a new Provisional Hospital Authority was established, to pave the way for a statutory independent Hong Kong Hospital Authority to come into operation in early 1990.
Details, as they are presently available, are given below. It is, however, pertinent at this stage to examine the recommendations the Review arrived at, not all of which by any means, are likely to be brought into effect. An examination of these proposals reflects how the Review may have attempted to tamper with some of the aspects of the prevailing hospital philosophy, whilst failing to alter the overall approach in any substantial way. This can only be expected, given the isolationist approach necessarily adopted.

5.2 Recommendations of the Consultancy Review

The Scott Review presented its recommendations under seven broad headings reflecting the original terms of reference and outlined below.

a. Hospital Authority Structure

The Review recommended that an independent Hospital Authority be set up as a statutory body with responsibility for all matters pertaining to the delivery of hospital services in Hong Kong. The Authority would be headed by a Board of up to 15 members with a full time Director of Hospital Services. The Authority Headquarters should fulfill central support and management functions and provide a range of clinical services planning functions.
New Hospital Regions would be established to create nine regions instead of the present five (in effect 4 as seen in 3.5). The proposed regional hospitals are shown in Figure 5.1. On Hong Kong Island two regions would be centred around Queen Mary (QMH) and the Pamela Youde Hospital (PYH) or the redeveloped Ruttonjee Hospital until its completion; Kowloon would comprise three regions centred around Queen Elizabeth (QEH), Kwong Wah (KWH) and United Christian Hospital (UCH); East New Territories would be divided into three regions centred around Tuen Mun Hospital (TMH), Princess Margaret (PMH) and Caritas (CMC) with the Caritas Region including parts of the northwest of Kowloon such as Lai Chi Kok, Cheung Sha Wan and Sham Shui Po. The exact boundaries of these regions were not given, neither was there much indication that service areas would be considered to be more important than at present.

However, each new Region would have a local Board of Management, chaired independently and with a Deputy Director of the Hospital Authority as a board member. "The Board will have a balanced representation...to include the local hospitals and community" (HK Govt, 1986a p. 12-4). The review recommended that "each region should include a range of hospitals providing different but complementary services; agreed roles and responsibilities would be outlined at Authority level and detailed by the Regional Board of Management" (p.12-4). There would
Figure 5.1 Regional hospitals proposed by the Consultancy Review, 1986
continue to be "supra Regional Services" such as Cardiology, Oncology and Neuro Surgery "requiring one or more centres of excellence in the Territory".

It was recommended that all Authority staff should work under common terms and conditions of service and be outside the Civil Service. Ultimately, all staff should be employed by individual hospitals (or groups of smaller hospitals) rather than by the Authority centrally. An independent Staff Advisory Commission should be set up reporting to the Authority but also "maintaining close links with Government".

Medical Policy would not be a main concern of the Hospital Authority. The Review recommended that "a strengthened medical policy function should be developed within the Health and Welfare Branch " of the Government Secretariat.

b. Internal Hospital Organization

A new structure of internal organization for hospitals was proposed. Fundamental to this was the introduction of a Chief Executive post at the hospital level, replacing the present situation where medical superintendents, chief nursing officers and chief administrators have, nominally at least, equal status. Such an executive role corresponds to the Unit General Manager post in the UK NHS reforms of the 1980s. Along with this comes an emphasis on
decentralizing of responsibility and accountability to hospital level and ward/department level. It lays heavy emphasis on professional rank and a clearer delineation of responsibility. The Review's recommendation that accounting and finance staff should report directly to Headquarters whilst still administratively managed by the Chief Hospital Executive is a significant provision. It is recommended that all staff except senior executives be appointed by the Hospital, subject to approval by the Regional Board of Management.

c. Measures to reduce hospital overcrowding

Here, the recommendations centre almost wholly on upgrading AED services and improving transfers within the system to maximize the utilization of all resources. As already indicated, no mention is made of the role of Community Nursing Services or other aspects of good intersectoral collaboration in preventing admission, readmission and promoting earlier discharge.

d. The Working Environment

The Review recommended that "there should be a clearer definition and recognition of the roles and relationships of staff at all levels within the Authority" with a greater delegation of tasks to those less qualified but capable of doing the tasks. This might assist in reducing consultant workloads, but inevitably this would only be
achieved through a greater number of senior doctor posts, with a consultant, senior medical officer and two medical officer team being responsible for at most 40-60 beds. The Review recommended that the Hospital Authority investigate the use of "well proven processes for the objective measurement of patient care and staff workloads" and that appropriate methods of formal and informal communication and opportunities for improved inter-staff communication should be established.

Included in the recommendations on the Working Environment is a section entitled "Development of individual hospital philosophy and character". In this it is recommended that each hospital be encouraged "to develop certain specific characteristics which it feels to be desirable, and which will distinguish it from other complimentary parts of the overall medical service within the Authority". To this end, a relatively small proportion of the annual budget should be given to the Chief Executive to use for this purpose "at his own discretion". Here, and in many other parts of the Review, it is hard to understand the role of the subvented hospital, a point repeatedly raised in submissions by the management boards of subvented hospitals in the consultation period. No mention is made of the possibility for a hospital to raise money for itself to enhance this special projects fund, an important point, remembering the relationship, for example, of UCH with Kwun Tong. The Review makes some mention of improved
teaching and research facilities, but these appear to relate to medical students and specific mention is not made of in-service training.

e. Hospital staffing

The Review recommends that the Hospital Authority adopt agreed ratios and constantly review progress towards these targets (a task that was supposed to be the responsibility of the MDAC previously). In an attempt to keep senior clinicians in public service, the Review recommends sessional contracts for some consultants, enabling them to do some private practice, a privilege at present reserved only for clinicians attached to the two Universities. The Review even mentioned that in the long term there might be provision for private doctors to visit patients in public hospitals, but it is unclear how the team saw this benefitting public hospitals.

f. Costs and cost control

Here, the Review recommends a complete change to the MHD outlook on expenditure, introducing the notion of consideration of outcomes, at least to patients whilst within the hospital system. It recommended that outcome components be required in regular financial reporting and that Divisional and Department heads be accountable for
the efficient and effective use of resources under their control. To aid in this, "internationally derived averages should be used as benchmarks against which total performance is monitored" with a heavy emphasis being placed on peer review systems.

g. Cost recovery and higher class accommodation

Lacking the authority to make recommendations for major raising of finance (such as through social insurance or taxation), the Review team were forced to restrict income generation largely to the area of fees. They recommended that the basis on which a standard day bed charge is made should be broadened from the present notional charge for food only, to something that more accurately reflected the cost of in-patient care, but the exact basis for this was not given. Presumably, in an attempt also to discourage the present phenomenon of "admission on demand", the Review argued for an admission charge be introduced to cover the administrative costs of a hospital admission, costs which would increase with improvements in the standards of hospital record keeping. It also argued for charges to be introduced to contribute to the costs of major procedures such as CAT scans, operations, certain drugs and laboratory tests. Attendance at AED should also be charged. The Review team remained confident that the existing arrangements for fee remission would suffice in ensuring that those unable to pay would not be denied treatment. The implication is that this increased income
could then be used for improved standards of food, accommodation and treatment, though this is not specifically stated.

In addition to this, the Review proposed that a new type of hospital ward/bed be introduced to offer higher hotel standards to those prepared to pay more. This kind of bed, to be introduced on a trial basis in one subvented hospital and one Government hospital, would bring in additional income, but it is significant that the team were forced to conclude that fees charged would not be high enough to make private sector insurance schemes attractive to the public. They seemed to suggest that for insurance to be a viable funding option, fees would have to be increased to very high levels. The Government, which has proved itself to be extremely reluctant to raise fees at all in the past, might consider such high levels politically unacceptable.

It is in the financial conclusions of the Review that many felt the greatest weaknesses were. For a consultancy connected to a major accounting firm, the level of analysis seems to be remarkably superficial. While conceding that an initial investment would be required to bring subvented hospital salaries up to Government levels and to create new posts in management and at clinical levels, it argued that other additional costs would be
small. This has evidently not been believed in Government circles. Neither has the contention of the Review that additional hospital beds would not be needed, other than those then in the planning stage. Given the failure to address the possibility of avoiding admission which a more imaginative examination of Community Nursing and Primary Health Care might have achieved, and the inescapable fact that Hong Kong has still got and will continue to have a rapidly increasing population, it is hard to see the basis of this claim. The Scott recommendations might make Hong Kong hospitals more effective in dealing with patients but they will do nothing to alleviate demand for hospital care unless fees were charged at a high enough level to prevent patients from presenting. It is questionable too, despite the great costs of hospital construction, that the Hong Kong Government would be willing to attempt to convince the public that more hospitals were not needed. Indeed, the Government makes increasing recourse to its hospital building plans in seeking popular approval. As seen in Chapter 2, hospital plans take a very long time to reach fruition and therefore to be paid for. Beds, on paper, are therefore a useful asset for Government public relations.
5.3 The Consultancy Review and the prevailing philosophy

In Table 5.1, the main aspects of Hong Kong Hospital philosophy discussed in Chapter 2 are re-examined in the light of recommendations of the Review. In some cases, the Scott recommendations reinforce existing trends and outlooks. In other cases, the recommendations sit uneasily in terms of the aspects of prevailing philosophy as identified in Chapter 2.

In terms of the prime function of the hospital, the recommendations reinforce the role of technological medicine by strengthening clinical power structures and suggesting methods of audit which not only make for "efficient" use of resources but also demonstrate medical effectiveness. There is little evidence that effectiveness will be considered outside the hospital bed stay. Therefore, the Review reinforces the importance of the hospital at the expense of community follow-up and care.

Clinical power structures are apparently strengthened through decentralization of decision-making, by making clinicians accountable financially and by raising the status and increasing the numbers of senior clinicians and through the introduction of peer review. The equating of employment terms between subvented and Government hospitals additionally raises the status of professionals in the subvented sector. In most of these, the Scott
<table>
<thead>
<tr>
<th>ASPECT OF PHILOSOPHY</th>
<th>DETAILS</th>
<th>MANIFESTATIONS</th>
<th>INFLUENCES (RELATED TO MODEL CONTRIBUTORY FACTORS)</th>
<th>CONSULTANCY RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime Function of hospital</td>
<td>Deals with disease by technological intervention in the cheapest &amp; quickest way</td>
<td>Short bed-stay in acute hospitals Acute hospitals have limited convalescent role</td>
<td>Western medicine dominant Role of medical professions Economic constraints of political-economic system</td>
<td>Reinforces idea of technological intervention but introduces element of cost</td>
</tr>
<tr>
<td>Perspective for overall evaluation</td>
<td>Short term</td>
<td>Failure to consider long term implications Evaluation on basis of each inpatient stay No/poor patient records</td>
<td>Dictates of bureaucracy Minimalist view of health Chinese culture (health perceptions/utilization behaviour) 1997 and the short-term syndrome</td>
<td>More attention to outcome but only outcome within the hospital. Evaluation based on comparisons between like circumstances</td>
</tr>
<tr>
<td>Determinant of resource use</td>
<td>Expense as opposed to cost</td>
<td>Dominance of minimalist health model Desire for very large hospitals Size of hospitals determined by economics</td>
<td>Economic constraints of political-economic system Dictates of bureaucracy Public reaction to taxatics</td>
<td></td>
</tr>
<tr>
<td>Role of technology</td>
<td>Highly restrained</td>
<td>Recurrent expense fear</td>
<td>Dictates of bureaucracy</td>
<td>Higher quality diagnosis important. Technology charges for patients</td>
</tr>
<tr>
<td>Official Aspirations</td>
<td>Greater expense efficiency Success in dealing with ad hoc demand</td>
<td>Criticisms of low utilization/long bed-stay Grandiose bed provision plans Desire for very large hospitals</td>
<td>Huge population growth Need to seek legitimacy</td>
<td>Higher standards without obsession with more beds</td>
</tr>
<tr>
<td>Relationship with Primary Care</td>
<td>Poorly developed -hospitals seen in isolation</td>
<td>Dominance of minimalist health model</td>
<td></td>
<td>Primary care ignored</td>
</tr>
<tr>
<td>Role of service area</td>
<td>Little function given patient behaviour</td>
<td>No attempt to influence service area or to relate service to local needs</td>
<td>Dictates of bureaucracy Low levels of local political development</td>
<td>No real difference New regions will be smaller - still centripetal relationship</td>
</tr>
<tr>
<td>Permeable Centripetal</td>
<td>Govt Community Nurses operate independently of hospital Poor referral links</td>
<td>Traditional separation of bureaucracy from the Chinese society Patient behaviour</td>
<td>More efficient transfers between hospitals may make areas more permeable</td>
<td></td>
</tr>
<tr>
<td>ASPECT OF PHILOSOPHY</td>
<td>DETAILS</td>
<td>MANIFESTATIONS</td>
<td>INFLUENCES (RELATED TO (MODEL CONTRIBUTORY FACTORS)</td>
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<tr>
<td>Client Access</td>
<td>No official restriction</td>
<td>Free AED philosophy</td>
<td>Chinese and Christian traditions (the role of charity). Need for working class safety net</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nominal cost/free cost up to the patient to present</td>
<td>Heavy overuse of AED admission on demand for questionable cases</td>
<td>Charges for AED increases in all charges. Higher charges for better class beds</td>
<td></td>
</tr>
<tr>
<td>Managerial Style</td>
<td>Centralised control even at Regional level</td>
<td>Top-down management by strict routines - management dominated by performance criteria devised externally to hospital</td>
<td>Colonial bureaucratic heritage - culture - role of order/&quot;face&quot; Role of professionals</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Move to decentralisation - new Regional Boards. Small budget for unrestricted use. Role of subvented hospitals unclear.</td>
<td></td>
</tr>
<tr>
<td>Public Participation</td>
<td>Nominal/Minimal</td>
<td>Restricted to subvented bodies Nominal participation on KDAC</td>
<td>Bureaucratic heritage Mediation at the interface between bureaucracy &amp; Chinese society Chinese culture (role of order/&quot;face&quot;) External pressures?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Some representation on Regional Boards Also on Hospital Authority - all appointed/not elected</td>
<td></td>
</tr>
<tr>
<td>Care Providers</td>
<td>A strict hierarchy of professionals with high definition of work Decision-making limited to clinical matters at each level Doctors get promoted into high management</td>
<td>Further entrenchment of professional interests - inflexible work practices Suspicion &amp; opposition to innovation</td>
<td>Western medicine dominant Role of professionals Chinese culture (role of order/&quot;face&quot;) bureaucratic heritage External influences on professional bodies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Attention to professional standards could reinforce prof. boundaries.</td>
<td></td>
</tr>
<tr>
<td>Internal Aspirations</td>
<td>Personal goals of excellence Genuine goals of caring</td>
<td>Individual career histories Research &amp; innovation despite impediments Job frustration Doctors' complaints</td>
<td>Professional interests Hierarchical system Individual expressions of conscience</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Peer review may make for better professional development and interest</td>
<td></td>
</tr>
<tr>
<td>Education function</td>
<td>Minimal</td>
<td>Education restricted to nurse training except teaching hospitals Staff not otherwise expected to progress</td>
<td>Economic restraints Entrenched university interests Same as those for prime function</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Little explicit mentioned. Climate may be more favourable. HK Academy of Medicine more likely to have effect.</td>
<td></td>
</tr>
<tr>
<td>Innovation &amp; research</td>
<td>Minimal</td>
<td>Conservative attitude Paranoia of expenditure</td>
<td>Economic restraints</td>
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recommendations are not at variance with the contributory influences as identified - i.e. the dominance of western medicine, the role of the professional and possible Chinese cultural interpretations of "face" and "order".

However, notions of decentralization of power may not fit in with Chinese cultural interpretations of order and face at the macro-level, nor are they likely to be enthusiastically received by a bureaucracy, schooled in a colonial heritage of top-down managerial styles. There is little evidence that such decentralization is occurring elsewhere in government structures in Hong Kong and so, it appears to be an isolated instance. The somewhat laudable suggestions of public involvement in not only the Hospital Authority itself, but also in the Regional Boards, attempts to expand public involvement where few parallels exist or are likely to exist. Here the external pressures of China's disapproval of democratic development in Hong Kong are likely to hold sway.

The increase in charges proposed fly very much in the face of the reasons why charges have never been substantially increased in the past. There may be large hurdles to overcome given the influence of Chinese and Christian traditions of charity, but also, where the position of the colonial state and its post 1997- successor is in essence weak, the giving of health care at nominal cost is part of the Government's search for public approval. This is
highly complex. The perception of poor quality health care diminishes the role of health care as a means of gaining support for the Government. So does increasing costs of that health care. Inevitably, any increase of cost to consumer will have to be accompanied by substantial and convincing improvement in service if any credibility of the state as a health care provider is to be maintained.

Any restrictions on AED access also conflicts with what clearly is an element of Chinese health care seeking behaviour. To introduce this without "converting" the public or providing acceptable alternatives will not be well received. One advantage of liberal AED access is that many cases are dealt with very promptly in terms of admission and treatment. This is clearly responsible for the generally short waiting lists in Hong Kong hospitals and may mean that cases which in the UK might take months of referral and waiting for specialist out patient appointments before waiting again for admission, are diagnosed and dealt with immediately. The UK system seems to introduce substantial costs through waiting whilst resulting in better, less overcrowded hospital conditions. Having said this, it must be noted that for charges to stop frivolous AED attendance, they would have to approach the average charge for private GP attendance, on average the equivalent of £7 - 10 and even these charges might not deter users at night-time.
In terms of the geographical implications, the Review recommendations have little potential impact. By increasing the number of hospital regions, smaller regional service areas and an upgrading of certain hospitals to become Regional Hospitals, may mean less need for most people to travel long distances. The Review makes no recommendations on increasing the impermeability of service area boundaries, indeed the service area as a concept remains very weak. Hospitals remain places to which patients come—a wholly centripetal relationship. Furthermore, in order to maximise use of all hospital beds, inter-hospital transfers, which presumably can also be inter-regional, are likely to increase (although the Review made no provision for expanded ambulance services or allowed for this cost). No new hospital locations are envisaged by the Review, although if the experimental higher hotel grade beds were to be successful, new hospitals or new wings would have to be built, possibly nearer middle income areas. The failure to enhance the service area’s importance is in keeping with the low levels of local political development that have been permitted as well as the predominance of technological medicine.

5.4 Details of the Government's response

This thesis has been completed at a time when many of the finer details of the Government's proposals are still
unclear. What is at present known, is dealt with below briefly. What is known seems to confirm the tendency, suggested already, for the Government to **partially** adopt consultancy findings, watering down some proposals and thereby affecting any cohesion that might have existed. The Scott recommendation of an independent hospital authority has been accepted in part. The membership of a 27 member Provisional Health Authority was finalised in November 1988. The Authority comprised 6 Government officers including the Secretary for Health and Welfare, the Deputy Financial Secretary, the Secretary for the Civil Service and the Director of MHD and two Deputy Directors. The rest of the membership includes three university professors of medical disciplines and three doctors, although none of these are in public service. After a period of heated public debate, professional workers within the Government service, rank and file professional staff were excluded from the membership, another example of a professionally led campaign that has served to detract from other issues at stake.

The Chair of the Provisional Hospital Authority, Sir Sze-yuen Chung, for long the senior member of the Executive Council, has had experience of heading organizations responsible for establishing commissioning bodies such as the City Polytechnic and the Hong Kong University of Science and Technology, although he has little medical experience. Servicing the PHA will be a
Secretary General, the former Secretary for Health and Welfare, whose appointment has been castigated as another instance of "jobs for the boys" (SCMP, 28/7/88). Indeed, it might be feared that the PHA draws too heavily on existing participants in the hierarchy, including the academic hierarchy, to be able to offer any substantially new and radical outlook.

The Provisional Hospital Authority is charged with the responsibility of setting up the mechanisms whereby the new statutory Hong Kong Hospital Authority can be inaugurated in April 1990 when the present MHD will cease to exist as such. Instead, there will be two Government departments - a Department of Health and a Hospital Services Department. The Hospital Services Department will then become the service arm of the independent Hospital Authority which was not something envisaged in the Scott Review. This splitting of the MHD, will lead to the downgrading of the post of Director to a rank, much to the disgust of the status-conscious Government Doctors Association, below that of the Director of Agriculture and Fisheries (HK Standard, 17/7/88).

The Hospital Services Department will comprise four divisions - professional service, administration, information and public relations and a "task force". The Hospital Authority will be responsible for the staff in the hospitals who will then cease to be civil servants,
although those who are already civil servants may opt to keep their civil service terms of employment. One advantage of an independent authority is its ability to pay staff on non-civil service pay scales. Indeed, the Government has indicated that an improvement in doctors pay is unlikely until 1990 as it would result in huge demands within the civil service for comparable treatment. However, this is a two-edged sword as similar discussion in the UK in connection with the "opting out" of hospitals has shown.

Employees of the Hospital Services Department will remain civil servants. The idea of an Authority with a Government service department is not without precedence in Hong Kong. This has been the arrangement in Housing since the early 1970s but in this case, the Authority does not also have a direct employment role. Under the Scott recommendations, neither would the Hospital Authority have employed a large number directly as hospitals would have been the main employers. To what extent this will be the case is as yet, unclear.

In terms of its operation, it is suspected that in many ways, the Hospital Authority will operate as does Hong Kong's University and Polytechnics Grant Committee (UPGC), and it is significant that the founding Chair is someone well versed in this organization. Like the UPGC, the Hospital Authority would each year receive from Government
a lump sum for which it has bid, and then reallocate this money in accordance with its own plans. To what extent it will be able to establish policy and dictate its own planning remains to be seen. Major change. in university policy, such as the proposed lengthening of undergraduate courses to four years, has met with stiff and successful Government opposition. It remains to be seen also, if the Hospital Authority will continue to have in its membership, those leading and powerful Civil Servants who are presently members of the Provisional Hospital Authority.

These incomplete details suggest that some managerial improvements will be possible within the hospital system although these will be hampered by the fact that it will be the same civil servants and their same bureaucratic habits at work. The common complaint about the lack of continuity in any Hong Kong Government department as staff are transferred in and out without apparently good reason, will still apply. Many questions remain too about the role of subvented hospitals and their management boards. In many ways, the subvented hospitals have been made the scapegoats of the problems, with the Government repeatedly implying that their underutilization has been at the heart of the Hong Kong hospital problem. It will need an exceptionally strong and independent Hospital Authority to transfer the resources needed to make subvented hospitals better utilized, away from the present big spenders in the
system. This is especially so, given the fierce competition for staff at all levels that results from the current emigration drain.

The signs so far show how anxious the Government is to retain control. This is seen particularly in the make-up of the PHA and the way professionals in the service have been excluded from decision-making and planning for the new Authority. With this precedent, some of the more enlightened recommendations of the Scott team with regard to decision-making at the clinical level seem unlikely to be implemented.

The battle ground with the medical professionals which has characterized the service for so long, has not been removed. Indeed, it could become more bloody as the medical profession strengthens its position. This will result perhaps more from another Government initiative that has been pursued at the same time than the review itself, namely the establishment of a Hong Kong Academy of Medicine. As has been seen, this working group has been charged with establishing the mechanisms for accreditation that Hong Kong now requires for its medical personnel as it can no longer be reliant on the accreditation that has been given by the Royal Colleges of the UK and Australia. The implications of this body for standards in Hong Kong hospitals (to say nothing of its possible role as far as hospitals in China are concerned) are potentially great.
The group comprises members representing powerful vested medical interests who seem determined to establish training facilities and opportunities within the hospital system. Perhaps this group, more than the trade unions, will ensure better working conditions. But it is unlikely that this body will do anything to change the overall philosophy of hospital care. If anything, it will strengthen the role of hospitals as technological centres to which clients are drawn. Intersectoral collaboration will not be seen as a priority. It is highly significant that the Hong Kong College of General Practitioners failed in its bid to be included as a founding college of the Academy.
5.5 Conclusion

In the Introduction to this thesis two predominant assumptions about hospitals in Hong Kong were highlighted - that they can be viewed in isolation and that the answer to the Hong Kong hospital "crisis" is more beds. In querying what hospitals in Hong Kong are really for, it has been shown that through a variety of factors a prevailing hospital philosophy has developed which is greatly affected by philosophies of technical medical intervention. Hospitals perform a curative role with little interest in longer-term health implications or outcome over anything but the shortest time spans.

For the geographer, the prevailing hospital philosophy has resulted in heavy development (perhaps over-development) of services at a few sites. These seem isolated not only from other health care providers but also environmental factors and local health care needs, whatever these may be. There is no anticipation of requirement, other than that in the crudest of projections. No importance is attached to prevention of modern diseases or avoidance of re-admission to hospital through a continuing care, long-term outlook.

This isolation of hospitals from populations served is reflected in official disinterest in service areas, the
boundaries of which appear to be quite permeable and unimportant. Hospitals have a centripetal relationship with the population and this further emphasises their dominance in the health care system, their apparent indispensibility and possibly their over-utilization. The centripetal relationship is also emphasised by an historical legacy of hospital location, at least in the older urban areas. As is the case elsewhere, there is considerable inertia in hospital distribution.

Internationally, challenges to such a medically dominated outlook in recent decades have suggested that this may not be a philosophy well suited to dealing with the health problems of the modern world. In the early 1970s, critics saw the answer in "community health". This would give an understanding of the real health needs of a community and encourage communal responsibility and involvement in health and health care. Care would in part be transferred from inside the hospital walls to the community outside, providing that such a community can be identified. In the 1980s, such notions were refined in the ideals of Alma Ata and the quest for intersectoral collaboration. These ideas have not missed Hong Kong by, but at least as far as the plans for the future of hospital services in Hong Kong are concerned, they seem to have had little impact.
This begs the question to what extent it is possible to change prevailing aspects of philosophy? Marxist and structuralist approaches would argue that the constraints imposed by the political economy or particular groups are so dominant that change is not possible. It has been seen (in Chapter 4) how in the case of the United Christian Medical Service an alternative philosophy with some apparent cohesion, if perhaps superficially or idealistically stated, has had some impact on certain aspects of local service delivery. However, when confronted with factors seemingly outside the organization's control, the United Christian Medical Service failed to implement the concepts of community health and intersectoral collaboration fully.

In the case of the Consultancy Review, no attempt was made to stray from the prevailing philosophical basis. Some aspects of philosophy were "tinkered" with, but largely in a framework of "greater efficiency" in a mechanical, managerial sense. The basis remains firmly entrenched in philosophies of medicine, with intersectoral collaboration totally ignored.

Whilst these developments appear to have left the prevailing Hong Kong hospital philosophy largely intact, it still does not necessarily follow that change is impossible over the long term. There are enough examples to justify the mechanisms for change suggested in
the expanded framework of Chapter 1, albeit working within the constraints that the wide collection of the contributory factors exert (and not just the singular dominance of the political economy).

Influences from outside Hong Kong remain important. Ideas can spread, even if the process is slow and the take-up patchy. The very fact that there is now a Hong Kong College of General Practitioners is an indication of a change in a particular direction. The Review stimulated discussion of audit for the first time in Hong Kong as well as revealing to many, the distinction between cost and expense.

Hong Kong professionals are not isolated from thinking elsewhere in the academic and professional worlds. In many senses, the Review was advanced for its time and raised issues, such as peer group review and audit, which were in their infancy elsewhere. The Review preceded the UK NHS White Paper by more than three years. In that time, there has been considerable progress in the fields of medical audit and clinical costing. The discussion generated by the UK White Paper and the attempts of Health Authorities to implement audit may ultimately provide more useful and practical suggestions than those of the Review. Indeed, should the "purchasing and providing" arrangements spawned by the NHS changes prove "successful" as a means of allocating resources and improving efficiency, there may
be considerable scope for their implementation in Hong Kong where providers are traditionally so diverse and where the idea of "independent" agencies, in the form of the subvented organizations is well established. Such contractual arrangements may actually provide an effective mechanism for some intersectoral collaboration.

Also, to suggest that the ideas and concepts promoted by UCMS (Chapter 4) have gone completely unnoticed would be unfair. There is evidence to support the innovative contribution of subvented agencies in general (e.g. Macquarrie, 1976; UCH, 1985b). What is clear from the UCMS experience is the importance of the way that ideas are packaged and "sold" to those in influential positions in the three key groups - the bureaucracy, the medical profession and consuming public. With Community Nursing, UCMS and the other subvented organizations involved, presented the Government with clear objectives, carefully devised trial programmes with fairly meticulous evaluation (Carter, 1975). While, as noted in Chapter 3, the Government is still to be fully convinced of the worth of community nursing which remains at variance to the prevailing outlook, it has nevertheless become a very established part of health care provision in Hong Kong. Its case for expansion is hampered by the fact that contemporary evaluation of CNS is poor. Statements continue to be made by advocates that CNS "saves hospital beds", but this potentially vital benefit remains
unmeasured and uncosted and therefore doomed to be ignored.

It is unfortunate that KTCHP has not followed the same formula as the early CNS advocates for its imaginative and interesting experiments. As Chapter 4 has shown, these initiatives for change have failed to make the same impact as Community Nursing because the organization has continued to work in isolation. Certainly, true intersectoral collaboration will be elusive in the absence of a co-operative and health promoting general practice system. As has been seen, this absence is partly a product of the interplay of consumer habits and the business interests of GPs, and small self-appointed organizations such as KTCHP have no hope of changing such relationships entirely on their own. However, they have a very important role as experimenters and demonstrators of good practice. But in order for this to be meaningful outside the confines of their own service areas and to people other than their own clients, their objectives have to be clearly identified, their work must be monitored and their projects rigorously evaluated. This was how CNS won acceptance and was replicated and maybe why so little of KTCHP's work has been taken up by others.

So where does this discussion leave the "crisis" of the Hong Kong hospital? Few health care workers encountered in the course of this research voiced much optimism that
post-Review developments would actually address the technical problems that continue to face Hong Kong hospitals, particularly the overcrowding of the wards. Given that the Review failed to address the question of why people continue to need hospital care at such a high level, its recommendations remain reactive rather than proactive. Continued dissatisfaction with hospital services is therefore likely, especially as emigration of skilled workers continues to take its toll.

Indeed, it may be that the problems will become worse. In the run-up to 1997, dejection and cynicism are not commodities in scarce supply in Hong Kong. Tien An Men on June 4th 1989 realised what many had always feared and the stream of talent and skills to Canada and Australia that has been a feature for decades became more like a torrent. For those who stay, there are opportunities in the jobs vacated, but this is little compensation for the loss of colleagues, the insecurity and uncertainty that this creates and the inevitable weakening of Hong Kong's position as a leading "little dragon". This is not a welcoming scenario for new ideas, for innovation or philosophical challenge. But those remaining in Hong Kong may be forced to consider if building more hospitals is the only way forward in health care in Hong Kong. As this thesis is completed, Tuen Mun Hospital, the latest MHD mega-project, remains unopened - for want of available nursing staff.
APPENDIX A

Clause 7 of the Alma Ata Declaration (WHO, 1978)

"Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of proper nutrition, an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works and communications; and demands the co-ordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources and to this end develops through appropriate education the abilities of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

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APPENDIX B

Items dealt with by the Medical Development Advisory Committee (MDAC) 1983-7

Session 1983-4

1. Supply of doctors
2. Supply of physiotherapists
3. Supply of occupational therapists
4. Supply of medical lab technicians & medical technologists
5. Supply of radiographers
6. Supply of dispensers and dispensing staff
7. Information paper on management review (Scott report)
8. Wai Long Hospital developments
9. Proposed Tai Po Infirmary and convalescent hospital
10. Hospital beds
11. Nursing services
12. Mental health services
13. Treatment for end-stage renal failure
14. Review of regionalization scheme
15. Our Lady of Maryknoll Hospital proposed extension

Session 1984-5

1. Clinical teaching
2. Scott consultancy brief
3. Post-graduate training in medical specialties
4. Review of the supply of doctors
5. Recommendations of a working group on a specialist register
6. Report of the central Coordinating Committee on overcrowding in hospitals
7. Working party on post-graduate training - Terms of Reference & Composition
8. The future development of small hospitals
9. Information paper on feasibility study on computerization
10. Opening up proceedings to the public - a letter from the Secretary of Health and Welfare
11. Clinic at Tin Shui Wai
12. Wong Chuk Hang Infirmary proposals
13. Additional eye beds at Buddhist Hospital
14. Treatment facilities for end-stage renal failure
15. Hospital beds

Session 1985-6

1. Choice of chair for postgrad working party
2. Our Lady of Maryknoll - revised proposals
3. Nursing services
4. Supply of doctors
5. Supply of physiotherapists
6. Supply of occupational therapists
7. Supply of medical lab technicians and medical technologists
8. Supply of radiographers
9. Hospital beds
10. Supply of dental personnel
11. Amendments to the Mental Health Ordinance

Session 1986-7 (items dealt with)

1. Health education
2. The Scott review
3. Dental subcommittee
4. Medical services for elderly
5. AED services
6. MDAC views on Scott
7. Scott & the subvented hospitals
8. Mersh role redevelopment
9. Hospice care
10. Mental health services

Session 1986-7 (items on agenda)

* 1. Clinics & Primary Health Care services
* 2. Infirmaries and Health Services for the elderly
* 3. Control of utilization of beds in the subvented
  4. AED services
  5. Health Education
* 6. School Medical Service
* 7. School Dental Service
* 8. Community Nursing and Psychiatric Community Nursi
  9. Mental Health
* 10. Neonatal screening service
* 11. Hepatitis B Immunization Programme
* 12. Treatment facilities for end-stage renal failure
  13. Progress reports on Scott, post-graduate
  Dentists subcommittee.

* = ITEMS NOT DEALT WITH
Case 1

Female aged 59 Lam Tin Estate Block 2 13th Floor

Four years ago the patient fainted whilst at work in a factory. She was taken to UCH by ambulance where a CVA was diagnosed. For unspecified reasons, she was immediately transferred to Queen Mary Hospital on Hong Kong Island for surgery. Since then she has had three more strokes leaving her totally bedridden, doubly incontinent and unable to speak. Recently, she has developed severe problems with swallowing leading to a doctor at UCH putting her on a commercial liquid diet costing over £3 per day (another doctor described this as "unimaginative management").

The woman lives with her husband (aged 67) who is dedicated to her constant nursing needs. He maintains that she needs turning every 2 hours. This has constrained his own activities and sleep. He is unable to leave the home for long periods. This means he is unable to leave the house long enough to queue at a Government clinic. Since he is unable to afford a private GP, he does not use a doctor, relying on traditional medicines, especially herbs, which he can boil at home. If the patient has problems, he has the number of the non-emergency ambulance to get her to AED or OPD. In a real emergency, he would dial 999.

His daughters and sons are all married and have left the nest. They continue to support financially and visit regularly. The unit is well appointed. The total receipts from Social Welfare (Public Assistance, Disability Allowance and Dietary Allowance) amount to approximately £130 per month (1986).

The nurse visits daily to check feeding, give physiotherapy and deal with the catheter tubes. She is admiring of the husband's care and devotion. He mentions what he describes as the "occasional miracles" - the odd time when his wife speaks a word or two; the unexpected, if slight movement of a limb.

In this case the intimate and caring home provides a far more satisfactory and economic alternative to the expensive hospital bed. The costs are passed on to the family, in this case particularly to the husband, in financial terms, but mostly in terms of the demands it has made on him. However, it is unlikely that he would want it any other way.
Case 2

Female aged 82  Lok Wah Tsuen, 2nd Floor

Two years ago, the patient fractured a femur in a fall. She was taken by ambulance to UCH AED where she was treated. Doctors in AED detected diabetes and so referred her to Medical OPD. Her blood sugar levels are not too high and so she is able to take oral medicine. The nurse visits to give and check her medication and to ensure that the lady is walking. Physiotherapy is needed and encouragement to walk with the Zimmer frame. She has not left the home for 2 months. Recently she scalded an ear which needs dressing.

The patient is on Public Assistance and Disability Allowance and is known to the Social Welfare Department. They have arranged a daily home help who cleans the room/washes the lady and cooks her 2 meals a day. The total cost for the home help including food is £1.10 per day. The nurse remits the CNS fee to £ 0.25 (1986).

The lady shares the unit with 2 other elderly ladies, who are not as disabled as she is. This share is arranged by the Housing Authority. The lady does not get on with her house mates and it would appear that there is substantial tension in the home. This is yet another example of the difficulties created by this system of allocating housing to the elderly single and needy. Both the home help and the nurse provide a valuable opportunity for the patient to have some friendly contact with the outside world. She uses the encounter to complain about everything.

Case 3

Male aged 22  Tsui Ping Road new blocks - 22nd floor

In October 1985, this patient had a major industrial accident resulting in serious head injury. He was rushed to QMH AED where he was admitted. The accident has left him a partial paraplegic with severe brain damage. His speech is slurred and his co-ordination defective. His recovery of walking is slow and he encounters serious difficulties in breathing and swallowing. Eating is consequently a problem. During the visit, the patient had a coughing fit and appeared in great discomfort. Additionally, he suffers from significant bouts of depression. His wife left him after the accident and he and his young daughter are cared for by his parents. They say he now "hates" his daughter.

The parents appear to be very supportive and caring. Their four daughters and three other sons have all left the nest, but make regular visits, with a regular reunion on
Sunday mornings. This is a long established Kwun Tong family having lived in the old blocks at Tsui Ping Road from the time of their construction some 30 years ago until their demolition. The unit is dominated by a huge fish tank and a prominent display of 5 prestige bottles of Brandy.

The nurse is not hopeful. This is a long term case where little progress is likely. As the parents become older and less able to look after the son, further difficulties will arise.

Case 4

Female aged 79 Yau Tong Estate, Block 2, 3rd Floor

This patient is a house-bound elderly lady who has been a long term sufferer from Parkinson's disease. She originally presented at UCH AED with a gangrenous toe. She had complained to the SWD home help of pain and the home help had informed her supervisor who had arranged for an ambulance to take the lady to hospital. The toe was amputated, but because of complications resulted in a long stay at UCH before transfer to Haven of Hope Sanitorium from which she was discharged and referred to CNS. The nurse visits to dress the wound and to administer the Parkinson's medication.

She lives with a male cousin who is over 80 years old. He is a colourful character, his cheery grin revealing a large array of gold plated teeth. He is very mobile and gets out and about, starting with yumchar (breakfast) every morning with his elderly cronies. He manages their finances, collecting her Disability Allowance and both their Public Assistance payments. The Social Welfare Department have offered her a place in a Care and Attention Home. He has refused and the nurse is convinced that this is because "he wants her allowance". They have a home help for washing only (£0.25 per day). The SWD have offered more help but this has been declined (the nurse says "he is too tight-fisted"). The unit smells badly - the culprit being a commode chair located behind a huge altar, the incense from which partly masks the odour. These old Yau Tong blocks still have shared toilets and the difficulties in getting infirm or elderly people to the toilets down the corridor are great.

This couple have clearly lived as man and wife. The old lady was very anxious to clarify the situation and to explain why they were never able to marry. According to her, it is Chinese tradition that if the mothers of the cousins are sisters then the cousins can marry. If not, marriage is prohibited which was the situation in their case. The nurse was not aware of this tradition. The man
has a son and daughter from a previous marriage who "have nothing to do with him".

He too, has had a lengthy association with UCH. He first heard of the hospital "on TV". Since then he was involved in a traffic accident and was taken to UCH by ambulance where he claims he had to stay for a year (the nurse queried this) for a pin and plate and long term traction. During this time he "became extremely good friends" with the Consultant of Orthopaedics. While he does not use a GP, he does make use of traditional medicine which he can recommend for knee joint pains. According to the nurse's translation, he sometimes "makes up a potion for the old lady" (!).

Superficially this extraordinary couple appear happy and able to cope. They evidently cause some concern to CNS, SWD and the SWD home help service, but seemed determined to continue in their own way. Such services as CNS and home help give such people a chance to avoid costly institutionalization. However, official agencies are uncomfortable with such freedom.
BIBLIOGRAPHY


Cable, J. (1985) "Budgeting for Health in Hong Kong", Public Finance and Accountancy, Vol 12, No. 1, pp 19-22

Carter, M.J. (1975) Community Nursing in Hong Kong, 1973-5, Department of Social Work, University of Hong Kong

Chan, Y.K. (1972) The growth pattern of organizations in Kwun Tong, Social Research Centre, Chinese University of Hong Kong


Cheng, J.Y.S., (1986) Hong Kong in transition, Oxford University Press, Hong Kong
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Publisher</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.N.S. (1973)</td>
<td>Bridging the Gaps</td>
<td>Committee on Community Nursing Services, Hong Kong</td>
</tr>
<tr>
<td>Crisswell, C.N., (1981)</td>
<td>The Taipans - Hong Kong's merchant princes</td>
<td>Oxford University Press, Hong Kong</td>
</tr>
<tr>
<td>Dwyer, D.J. (ed) (1971)</td>
<td>Asian urbanization - a Hong Kong casebook</td>
<td>Hong Kong University Press</td>
</tr>
<tr>
<td>Endacott, G.B. (1973)</td>
<td>A history of Hong Kong</td>
<td>Oxford University Press, Hong Kong</td>
</tr>
</tbody>
</table>


Great Britain (1976) Prevention and health: everybody's business, Department of Health & Social Security


Green, D.G. (1985) Working class patients and the medical establishment, Gower


Hardie, M. (1985) "Hospital and Community" in International Hospital Federation Yearbook, pp 77-80, International Hospital Federation, London

Harris, P. (1978) Hong Kong - A Study in Bureaucratic Politics, Heinemann, Hong Kong

Ho, S.Y.C. and Donnan, S.P.B. (1985) "Dietary practices and illness behavior among a Hong Kong community", Journal of the Hong Kong Society of Community Medicine, Vol 15, No.2, pp 5-14

Ho, S.C. (1985) "Dietary beliefs in health and illness among a Hong Kong community", Social Science and Medicine, Vol 20, No. 3, pp 223-230
The development of health services
Hong Kong Government Printer

Hong Kong Population and Housing Census, 1971, Main Report,
The Hong Kong Government Printer

The Further Development of Medical Services in Hong Kong,
The Hong Kong Government Printer

1976 By-Census Report,
The Hong Kong Government Printer

Hong Kong 1981 Census, Tertiary Planning Unit tabulations,
Hong Kong Government Printer

Hong Kong 1981 Census, street block/village cluster tabulations, New Kowloon,
The Hong Kong Government Printer

Hong Kong 1981 Census, graphic guide,
The Hong Kong Government Printer

Hong Kong 1983
The Hong Kong Government Printer

The Delivery of Medical Services in Hospitals,
The Hong Kong Government Printer

Statistical Report on the Community Nursing Service 1985-6,
Medical and Health Department, Hong Kong

Director of Medical and Health Services, 1986-7 Departmental Report.
The Hong Kong Government Printer

Hong Kong 1986 By-census, District summary tables,
The Hong Kong Government Printer

Hong Kong 1986 By-census, District tabulations for Kwun Tong,
The Hong Kong Government Printer

- 440 -
<table>
<thead>
<tr>
<th>Source</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.K. Govt. (1987d)</td>
<td>Hong Kong Population Projections, The Hong Kong Government Printer</td>
</tr>
<tr>
<td>H.K. Standard</td>
<td>(see note on use of newspapers in the Introduction)</td>
</tr>
<tr>
<td>Hong Kong Observers, (1983)</td>
<td>Pressure Points, Summerson (HK) Educational Research Centre, Hong Kong</td>
</tr>
<tr>
<td>Ingram, D., Clarke, D.R., Murdie, R.A. (1978)</td>
<td>&quot;Distance and the decision to visit an emergency department&quot;, Social Science and Medicine, Volume 12, pp 55-62</td>
</tr>
<tr>
<td>Johnston, R.J. (1985)</td>
<td>&quot;The world is our oyster&quot;, in King, R. (ed), Geographical Futures, pp 112-128, Geographical Association, Sheffield</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
</tr>
<tr>
<td>-----------</td>
<td>------</td>
</tr>
<tr>
<td>Kennedy (1983)</td>
<td></td>
</tr>
<tr>
<td>King, A.Y.C. and Chan, Y.K. (1972)</td>
<td></td>
</tr>
<tr>
<td>Kingma, S.J., 1982</td>
<td></td>
</tr>
<tr>
<td>Koo, L.C., 1987</td>
<td></td>
</tr>
<tr>
<td>KTCHP (1970)</td>
<td></td>
</tr>
<tr>
<td>KTCHP (1979)</td>
<td></td>
</tr>
<tr>
<td>Lau, S.K., 1984</td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Lee, R.P.L.</td>
<td>1972</td>
</tr>
<tr>
<td>Lee, R.P.L.</td>
<td>1974</td>
</tr>
<tr>
<td>Lee, R.P.L.</td>
<td>1975</td>
</tr>
<tr>
<td>Lee, R.P.L.</td>
<td>1983</td>
</tr>
<tr>
<td>Leeming, F.</td>
<td>1973</td>
</tr>
<tr>
<td>Lethbridge, H.J.</td>
<td>1978</td>
</tr>
<tr>
<td>Li, A.M.C.,</td>
<td>1985</td>
</tr>
</tbody>
</table>

Lim, W., Chan, J. and Saw, D (1985) "Mycobacterium chelonii infections - a report of 8 cases", Journal of the Hong Kong Medical Association, Vol 37, No. 1, pp 35-6

Lo, M., Kleeven, J.W.L. and Lam, T.H. (1985) Primary Health Care in Hong Kong and the Kwun Tong Community Health Project, Department of Community Medicine, University of Hong Kong

Longstaff-Mackay, J. and Lo, G.C.C., 1985 "Wife Battering in Hong Kong", Journal of the Hong Kong Medical Association, Vol 37, pp 23-26


Macquarrie, L.B. (1976) Readings in Hong Kong Social Policy and Administration, Hong Kong Council of Social Service

Mattock, K. (1984) Hong Kong Practice: Drs. Anderson and Partners - the first hundred years, Drs. Anderson and Partners, Hong Kong


McDermott, K. (1986) "Community Health and reform in Hong Kong", Social Science and Medicine, Vol 23, No. 2 pp 191-199

Miners, N.J. (1977) The Government and Politics of Hong Kong, Oxford University Press, Hong Kong


Navarro, V., 1976, Medicine under capitalism, Frodist, New York

Newell, K.W. Health by the people, World Health Organization, Geneva (1975)

Ng, A., 1986, "Prescribing a cure for the health system", South China Morning Post, 13th April 1986


Paterson, E.H. (1987) A hospital for Hong Kong, Alice Ho Mui Ling Nethersole Hospital, Hong Kong


<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powell, J.E.</td>
<td><em>Medicine and Politics: 1975 and after</em></td>
</tr>
<tr>
<td></td>
<td>Pitman Medical, London</td>
</tr>
<tr>
<td>Pryor, E.G.</td>
<td><em>Housing in Hong Kong</em></td>
</tr>
<tr>
<td></td>
<td>Oxford University Press, Hong Kong</td>
</tr>
<tr>
<td>Rabushka, A.</td>
<td><em>Value for money: the Hong Kong budgetary process</em></td>
</tr>
<tr>
<td></td>
<td>Hoover Institution Press, Stanford</td>
</tr>
<tr>
<td>Relph, E.</td>
<td><em>Place and placelessness</em></td>
</tr>
<tr>
<td></td>
<td>Pion</td>
</tr>
<tr>
<td>Rifkin, S.B.</td>
<td><em>Community health in Asia</em></td>
</tr>
<tr>
<td>(ed)</td>
<td>Christian Conference of Asia, Singapore</td>
</tr>
<tr>
<td></td>
<td>&quot;Planners' approaches to community participation in health programmes: Theory and reality&quot;,</td>
</tr>
<tr>
<td></td>
<td><em>Contact</em>, No. 75 pp 3-16</td>
</tr>
<tr>
<td>Rifkin, S.B.</td>
<td><em>Health planning and community participation - case studies in South-East Asia</em></td>
</tr>
<tr>
<td></td>
<td>Croom Helm, London</td>
</tr>
<tr>
<td>Rifkin, S.B.</td>
<td>&quot;Lessons from community participation in health programmes&quot;, <em>Health Policy and Planning</em>,</td>
</tr>
<tr>
<td></td>
<td>Vol 1, No. 3, pp 240-249</td>
</tr>
<tr>
<td>Russell, L.B.</td>
<td><em>Is prevention better than cure?</em></td>
</tr>
<tr>
<td></td>
<td>The Brookings Institute, Washington</td>
</tr>
<tr>
<td>Scherer, J.</td>
<td><em>Contemporary community: Sociological illusion or reality</em></td>
</tr>
<tr>
<td></td>
<td>Tavistock Publications, London</td>
</tr>
<tr>
<td>SCMP</td>
<td><em>(see note on use of newspapers in Introduction)</em></td>
</tr>
<tr>
<td>Seedhouse, D.</td>
<td><em>Health: the foundations for achievement</em></td>
</tr>
<tr>
<td></td>
<td>John Wiley and Sons</td>
</tr>
<tr>
<td>Smart, B.</td>
<td><em>Michel Foucault</em></td>
</tr>
<tr>
<td></td>
<td>Ellis Horwood, Chichester</td>
</tr>
<tr>
<td>Smith, D.M.</td>
<td><em>Human Geography: A welfare approach</em></td>
</tr>
<tr>
<td></td>
<td>Edward Arnold, London</td>
</tr>
</tbody>
</table>

- 446 -


Tong, E.K.M.W., (1985) "Morbidity patterns in a community health centre - a two year study", The Hong Kong Practitioner, August 1985


UCH (1985a) Submission on Consultancy Terms of Reference, United Christian Hospital, Hong Kong

UCH (1985b) The United Christian Hospital and the subvented hospital system, United Christian Hospital, Hong Kong

UCMS (1987) UCMS Annual Report 1987, United Christian Medical Service, Hong Kong


<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Publisher/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willcocks, A.J.</td>
<td>The creation of the National Health Service</td>
<td>Routledge and Kegan Paul, London</td>
</tr>
<tr>
<td>(1967)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wilson, M., 1975,</td>
<td>Health is for people</td>
<td>Darton, Longman and Todd</td>
</tr>
<tr>
<td>Wong, L.S.K. (ed)</td>
<td>Housing in Hong Kong: a multi-disciplinary study</td>
<td>Heinemann Educational, Hong Kong</td>
</tr>
<tr>
<td>(1978)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>