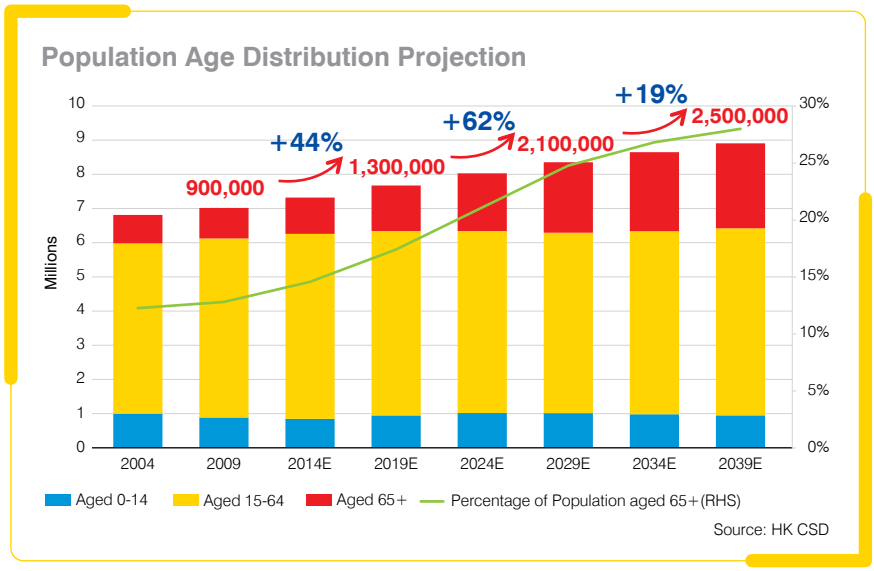
2: Hong Kong's Excellent Medical System is On the Brink of Breaking Down—Upsurge in Demand for and Stagnating Supply of Medical Services will Startle our Medical System within These Few Years

(1) Demand for medical services is surging ahead at an increasing pace

(1.1) Ageing demographics: Our elderly population (defined as people aged 65 or above) is expected to more than double the current number to over 2m by 2029

Our population statistics show that Hong Kong will be experiencing a demographic phenomenon that has never occurred before. The number of elderly people will more than double in 20 years' time from c.900,000 to c. 2.1m (i.e. up over 4% p.a.), and close to triple (up 170% from 900,000 to 2.5m) by 2039. This has serious social implications, as our services for elderly people, including demand for medical services, will undoubtedly shoot up at a pace that our services cannot catch up with.

Medical attention will spike in 15 years, and the effects of ageing population will witness an unprecedented change in our society's resource distribution



(1.2) Elderly people require almost six times as much inpatient care than those younger

Elderly people require almost six times the amount of inpatient care compared to those younger. This is because elderly patients pay on average 4.7 times the number of visits to hospitals compared to those younger and still an elderly inpatient's average length of stay at hospitals is 1.3 times that of younger patients. In other words, even if our population did not grow, medical attention would increase at a pace that Hong Kong has never experienced before, let alone the fact that our population will be increasing by 0.7% each year. In public hospitals alone, elderly people account for 42% of all inpatient admissions.

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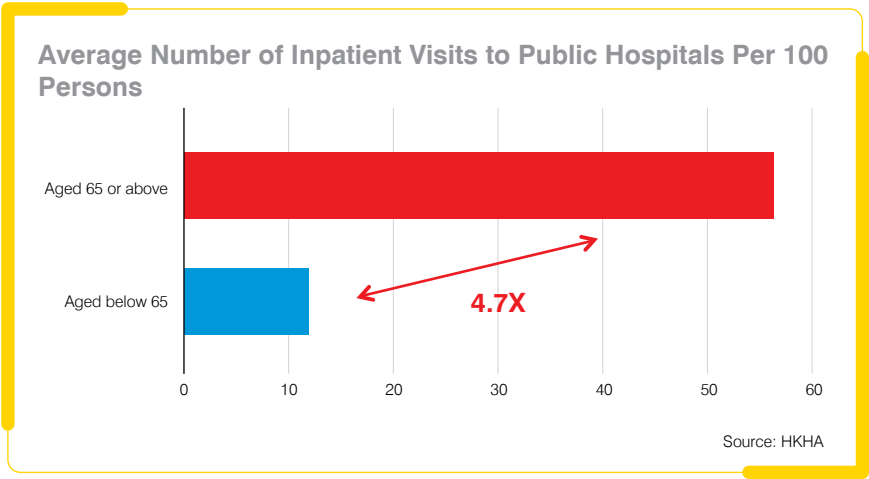
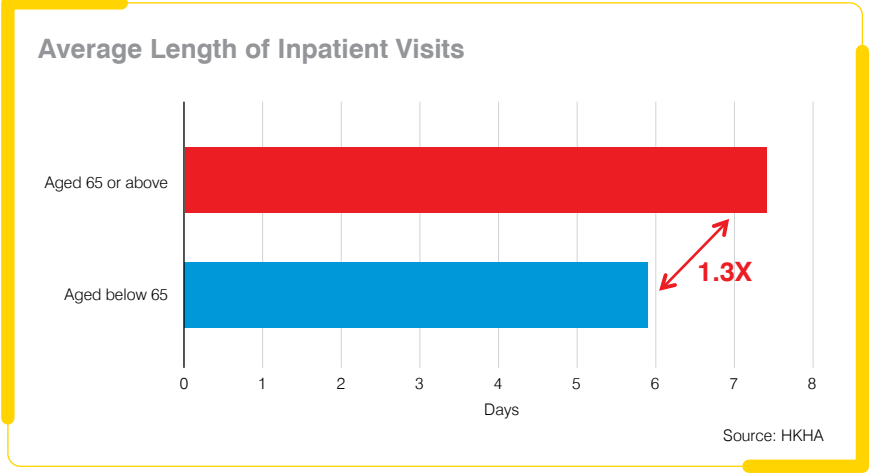


Elderly patients pay on average 4.7 times the number of visits to hospitals compared to those younger



An elderly inpatient's average length of stay at hospitals is 1.3 times that of younger patients

Elderly people account for 42% of all inpatients, and this proportion has been increasing from c.38% to 42% between 2000 and 2009 when the elderly population has increased by 165,000 (or 23%). This proportion is expected to increase to 50% by 2019 (or up 1.9% p.a.) and 62% by 2029 (or up 2% p.a.).

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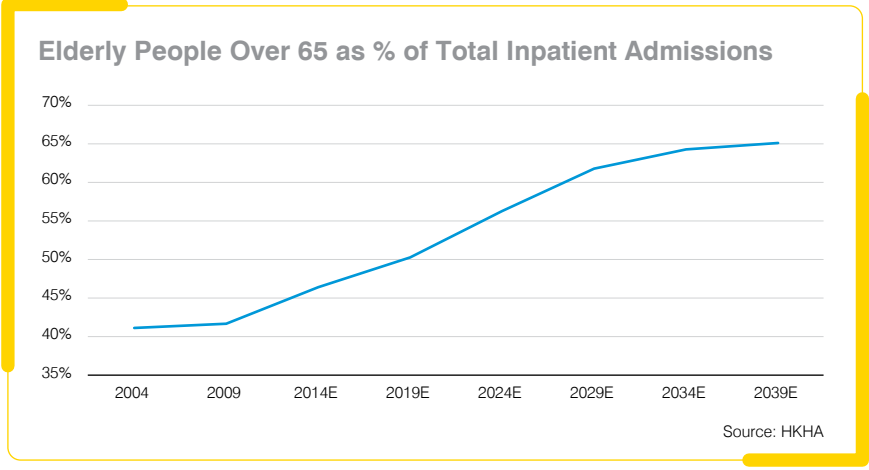
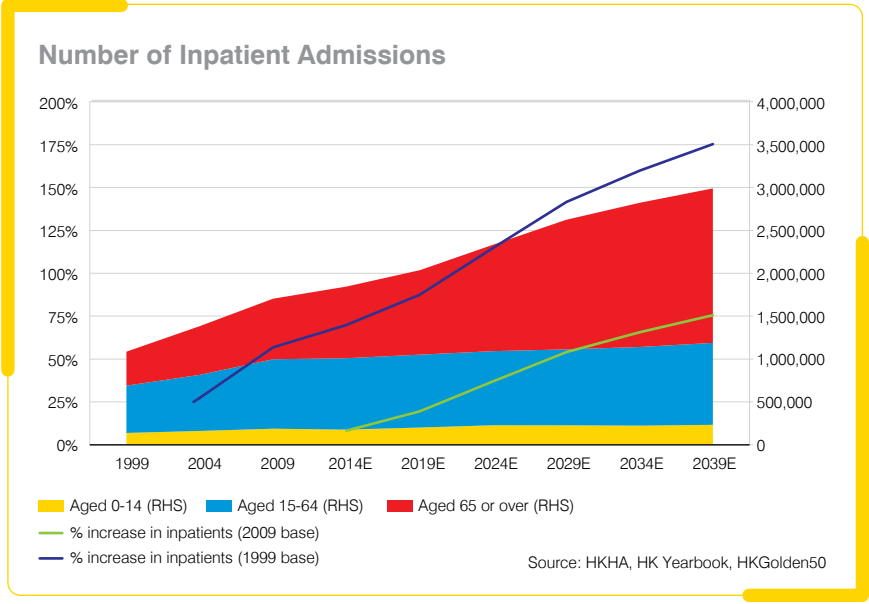


(1.3) Population growth: According to government forecast, our population will grow 1.9m to 8.9m by 2039, or an increase of 27% in 30 years

According to government forecast, our population will grow 1.9m to 8.9m by 2039, or an increase of 27% in 30 years. Combining the effects of ageing and population growth, our population demographics will increase inpatient admissions number by 55% in 20 years (adding c.900,000) and 75% (adding c.1.3m) in 30 years, even if we assume that patients do not request for more services in the future (which is highly unlikely in Hong Kong's experience). In other words, Hong Kong will have an 1.9% increase in patients per year, 1.1% faster than our population growth rate. If we cannot handle an upsurge of 42,000 more births to 89,000 since 2003, how can we expect our system to carry 1,300,000 more inpatients? Anyone with chronic disease who looks at the chart below would most likely come up with a backup plan to move elsewhere in 20-30 years' time.

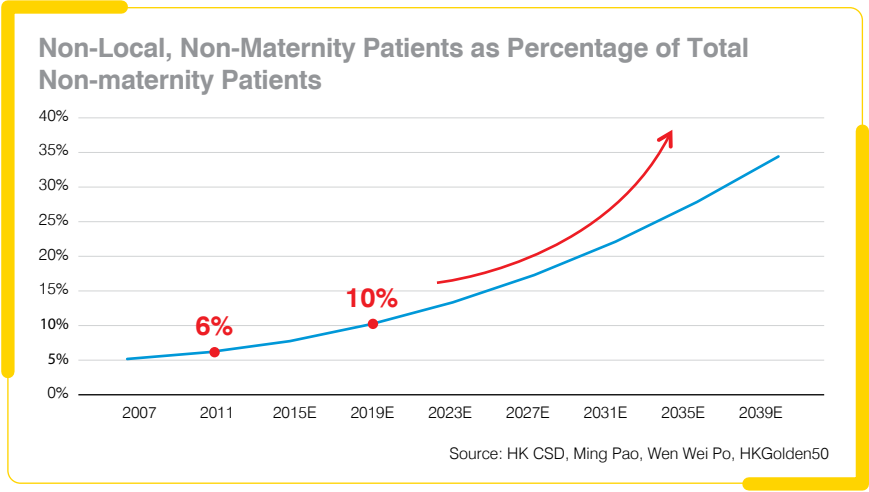
Currently, Hong Kong has c.1.7m inpatients per year, this will be up 55% in 20 years and 75% in 30 years; if we cannot handle an upsurge of 42,000 more births to 89,000 since 2003, how can we expect our system to carry 1,300,000 more inpatients by 2039 with our current capacity?



(1.4) Surging demand for quality private healthcare from the region: Patients from mainland China demanding non-maternity medical care at private hospitals surged 50% in the past four years (i.e. roughly 11% growth p.a.). This rate of growth is expected to remain high, a phenomenon similar to dynamics that lie beneath the 50% leap in tourist arrivals between 2009 and 2011

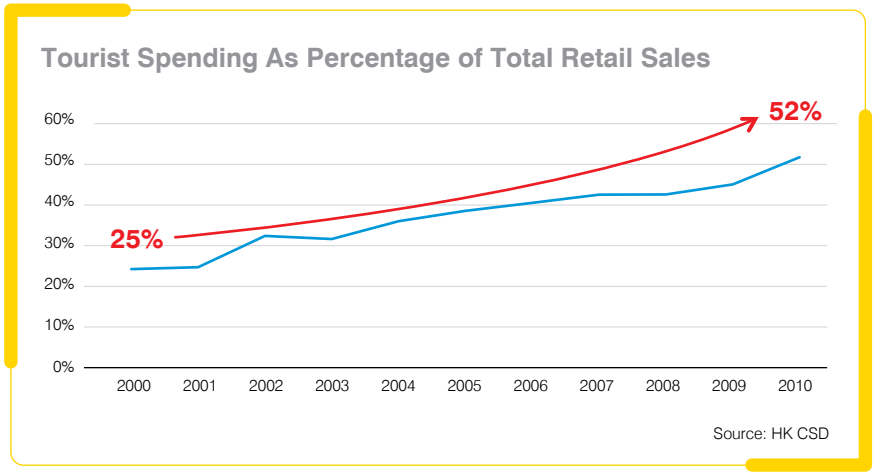
Mainland patients for non-maternity care grew 11% p.a. between 2007 and 2011

Besides our growing local demand for medical healthcare, mainland demand for our medical services is increasing concurrently. For the past few years, we have been flooded by media reports on mainland demand for maternity services, yet this phenomenon is not only an isolated case. Between 2007 and 2011, non-local non maternity patients at private hospitals increased by 50%, achieving a 11% growth p.a., double the growth of local patients (p.a. 6%). In the upcoming 20 years, non-local non-maternity patients will make up an increasing proportion of our total private medical demand, expected to take up one fifth by 2030 and up to 35% by 2039.



Upsurge trend likely to parallel our J-curving mainland tourist arrivals, up 80% since 2007

This growth parallels with 16% growth p.a. in our mainland tourist arrivals, which has been increasing by 80% since 2007. As more mainland tourists come to Hong Kong and discover our World-Class medical services offering on top of quality retail services, mainland tourists will soon be bitten by our "Hong Kong medical bug". (Please refer to section 3 to appreciate the huge gap in medical service performance between Hong Kong and the mainland). This trend is already forthcoming—a 48,000 sf Medical Centre taking up the entire 12/F of Ocean Centre was recently opened in 2012 at the heart of our "mainland tourist district". Comprehensive medical services from Matilda Hospital's clinic, Medinet Health Centre and other private practitioners are now readily available to mainland customers after their shopping spree on Canton Road.



By 2016, the Guangzhou-Shenzhen-Hong Kong Express Rail Link will offer Guangzhou's affluent middle class quality Hong Kong medical services 48 minutes away

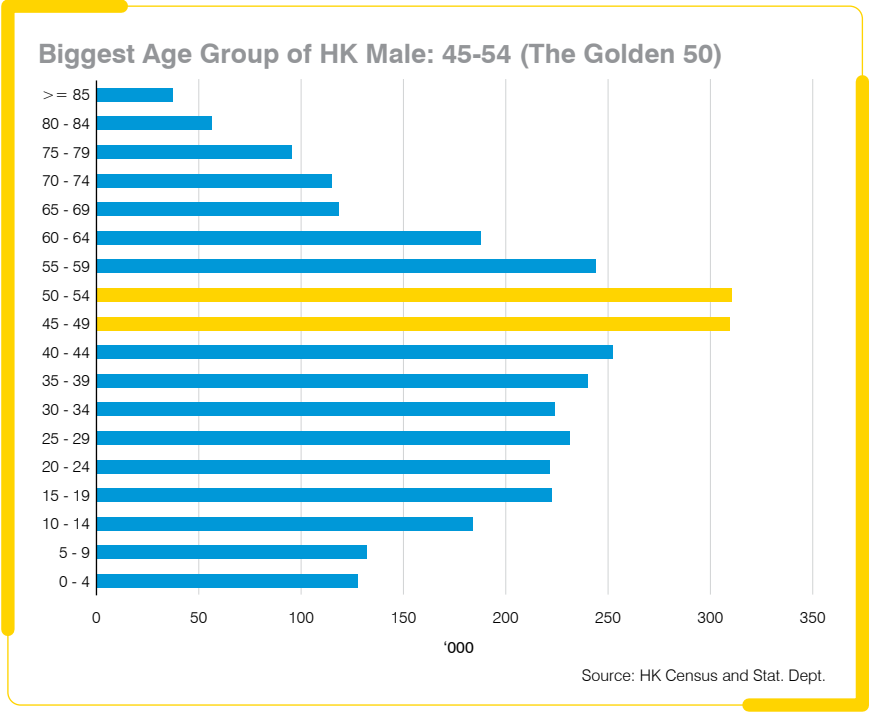
A typical affluent Chinese middle class first goes through the consumption of brands, and the consumption of quality services like medical care and education follows. With the opening of the HK$62bn Guangzhou-Shenzhen-Hong Kong Express Rail Link in early 2016, Hong Kong will put the rapidly growing middle class of the affluent Guangdong cities of Guangzhou, Dongguan and Shenzhen within an easy 48 minutes' reach of World-Class Hong Kong healthcare services. It is highly likely that our medical services will ride a similar trend parallel to our tourist spending's growth—In 2010, tourist spending accounted for 52% of our total retail sales, up by c.30% since 2000.

(2) Supply of doctor service is stagnant

(2.1) Retirement tide: 5,000 doctors (or 40% of our current c. 12,800 doctor workforce) from the baby boomers' generation will be retiring in the next two decades, just as our ageing population requires unprecedented amount of medical care. The upshot is that the shortfall in doctor hours against what is required, will widen significantly – from the 4% in 2009 to 25% by 2019 (i.e. up 2.1% p.a. from 2009 to 2019) , to 45% by 2029 (i.e. up 2.0% p.a. from 2019 to 2029) and to 47% by 2039 (i.e. up 0.2% p.a. from 2029 to 2039). This suggests that our wonderful medical system is at or is fast approaching a "breaking point"

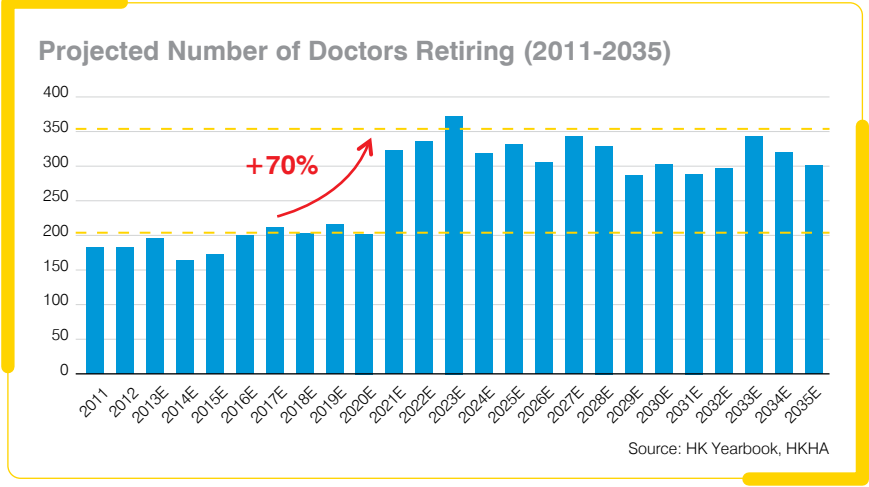
Increasing medical demand coupled with the retirement tide of doctors will cripple our system

Our third report highlighted the effects of our ageing population's retirement tide—our labour force has been growing by c.10% over the last decade, yet with the big bulk of baby boomers retiring in a decade or two, our labour force will contract by some 7% in ten years' time. A similar case applies to doctors. Take doctors working within the HKHA for example, which accounts for approximately 40% of the total registered doctors in Hong Kong; there are some 1,100 doctors aged 47 or above within HKHA, or approximately 20% of the public doctor workforce. Many of these are senior doctors with rich experience and have the best medical skills. However, within the next two decades, these doctors will be retiring and hopefully they will have passed the baton of knowledge to the new generation. The number of private doctors is even more startling, as many of them set up private practices earlier in their career-- c. 4,000 doctors aged 46 or above are still registered as practicing in the private sector. These 4,000 boomer private doctors together with the 1,100 retiring HKHA doctors (c. 5,000 doctors in total) account for 40% of the total doctor population.



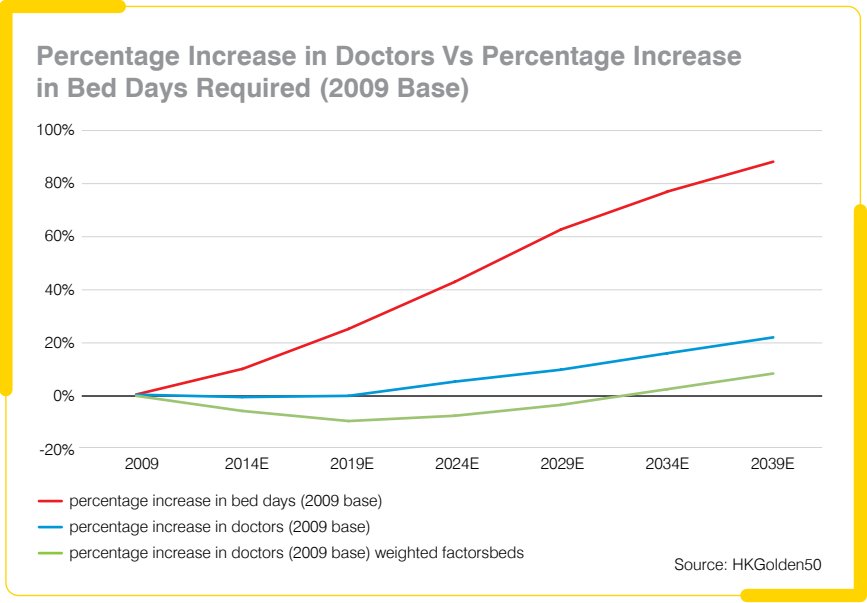
By the early 2020s, there will be a spike in retirees, with more than 300 doctors retiring each year. Retirement trend will gap up 70% within the next few years and between 2025 to 2035, there will be some 3,000 doctors retiring in total, accounting for 25% of the total number of doctors. In other words, a quarter of our doctors will retire at the same time as the number of elderly people hit a new high at 2m, accounting for one-fourth of our total population. This calls for an urgent increase in medical hardware and software.

Retirement trend will gap up 70% within the next few years: A quarter of our doctors are retiring in a decade between 2025 to 2035



With 5,000 retiring and only some 280 doctors on average trained annually for the past decade, the number of doctors will be stagnant for another ten years. By 2019, we will only have 12,400 doctors, essentially the number of doctors in 2009, despite a 25% increase in medical demand for inpatient services. By 2029, the 13,600 doctors make up a 10% increase in doctors since 2011, yet medical demand would have risen by c.63%. By 2039, there will only be c.15,000 doctors in total, an increase of 20% of doctors from 2009, yet the number of inpatients by itself is expected to surge by 88% due to an upsurge in elderly population. A severe shortfall of doctors is hence imminent.

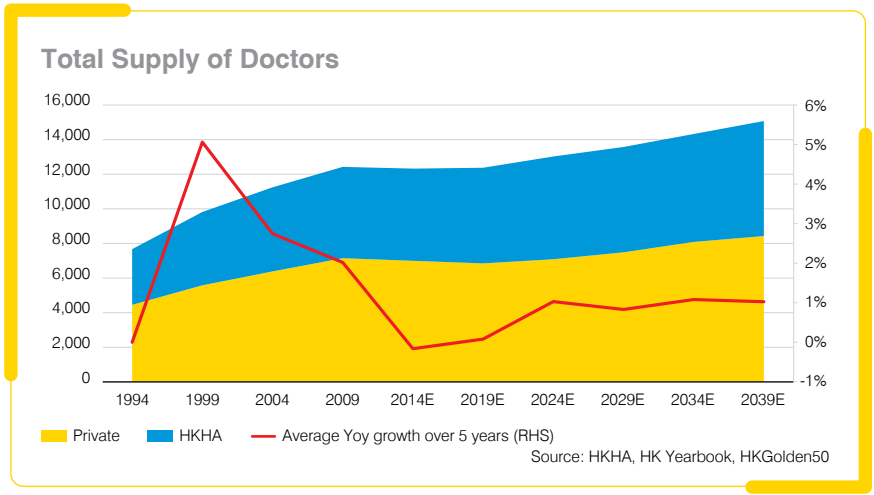
The total number of doctors will be stagnant for the next decade, and will only grow by 25% 30 years from now



(2.2) Competency gap: A retiring doctor is far more experienced than a young doctor. The 420 students who will be joining medical school are supposed to replace the boomer doctors, but will not graduate until 2018. Individually, their experience is less than the 5,000 doctors reaching their retirement age between now and 2030. In fact, not until mid-2020s can the 420 doctors have accumulated enough experience to become specialists

Replenishment rate is not fast enough—one-third of all doctors will retire in the next two decades

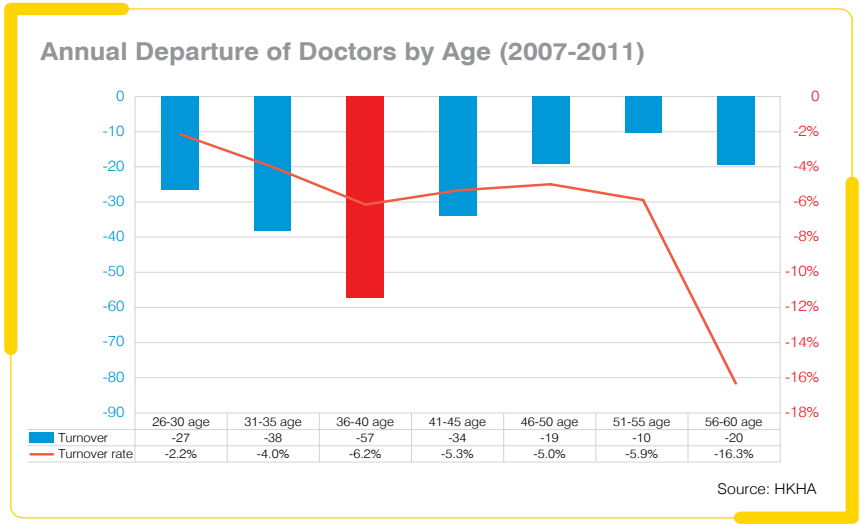
Even though the government has just approved funding for 420 university places (up 30% from the 1990s, but up c.50% from the 2000s) for medical students per year starting in 2012 to make up for the substantial shortage in the last decade, the replenishment rate will not be fast enough to meet the demand for the next ten years because the 420 medical students will not graduate until 2018, and their experience and ability are most likely incomparable to the 5,000 doctors reaching their retirement age between now and 2030. In fact, only by 2025 will the first batch of 420 doctors have accumulated enough experience to be specialists. Consequently, not only are we not replacing enough doctors by a quantitative measure, we are also not replacing the retiring doctors with the same level of experience.



(2.3) Generation gap: In line with changing society norms, young doctors demand shorter work hours, better work-life balance and preference for specialising in less challenging disciplines

Call for shorter work hours per worker heightens demand for more doctors

While demand for healthcare continues to grow and effective supply of doctors continues to shrink, junior doctors are also demanding shorter work hours—a common phenomena among the younger generation. Compared to firefighters' demand of 48 work hours per week, a request for working less than 65 hours a week from the 70+ hours work week appears to be reasonable. Professor Joseph Sung Jao Yiu, the Vice Chancellor of Chinese University, noted in an SCMP interview in April 2012 that "the social values of young doctors have changed". The request for shorter work hours reflects the trend that new doctors appreciate and value a better work-life balance, and perhaps treat their work more as an occupation and less of a mission. Many of them are hence turning to private sector, where they can work shorter and more flexible hours, once they have obtained their specialist training at the age of 36-40. The graph below shows this phenomenon—c. 30% of HKHA doctors leaving the system come from this particular age group. This age group also has the second highest departure rate (6.2% p.a.), only lower than the 56-60 (16% p.a.) group. The latter group has a high departure rate as those doctors are near retirement age. On the other hand, those aged 36-40 leave mostly because they have decided to switch to private practice after obtaining their specialist recognition.



New generation of doctors prefer less challenging areas of medicine

Apart from demanding better work-life balance, junior doctors are less inclined to take up the more challenging specialites such as Internal Medicine. With similar pay and much longer working hours, statistics are showing that the new generation of doctors has shyed away from very demanding specialties. For the past two years, only two doctors registered to become specialists in Internal Medicine (a specialty especially important for our ageing population, as all chornic disease patients have to consult internal medical specialists). This critical speciality's increase in numbers pales in comparison with the twenty doctors added to Anaesthesiology, which is one of the new favourites among junior doctors, as the specailty offers relatively shorter hours and fewer overnight shifts.

Number of Newly Registered Specialists

Specialists registered	5-Year Growth (2006-2010)	5-Year Growth (2006-2010)	10-Year Growth (2001-2010)	10-Year Growth (2001-2010)
Internal Medicine	0	0%	2	2%
Paediatric Surgery	9	7%	28	26%
Paediatrics	48	11%	139	41%
Obstetrics and Gynaecology	38	12%	75	26%
Plastic Surgery	5	12%	15	47%
General Surgery	66	20%	168	71%
Anaesthesiology	64	25%	157	93%
Geriatric Medicine	21	27%	46	85%
Psychiatry	79	46%	149	145%
Emergency Medicine	82	57%	164	260%
Total specialists	**984**	**24%**	**2169**	**76%**

Source: HKHA

(2.4) More female doctors: The number of female per 100 male doctors has doubled over the past 30 years from 19 to the highest point at 40. Female doctors tend to retire and/or switch to part-time when they reach their 30's to take up maternity and childcare responsibilities. The rising trend of more female doctors therefore reduces the hours worked

Over the past three decades, the number of female per 100 male doctors has doubled for the past 30 years from 19 to the highest point at 40. This trend is set to continue, as the current intake of students from our two local medical schools have admitted more female than male students for three years out of five years between 2004-2009.

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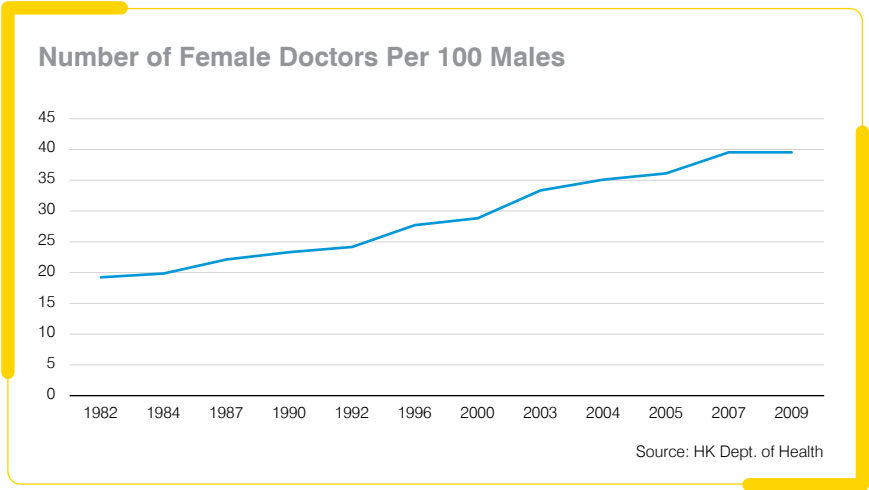
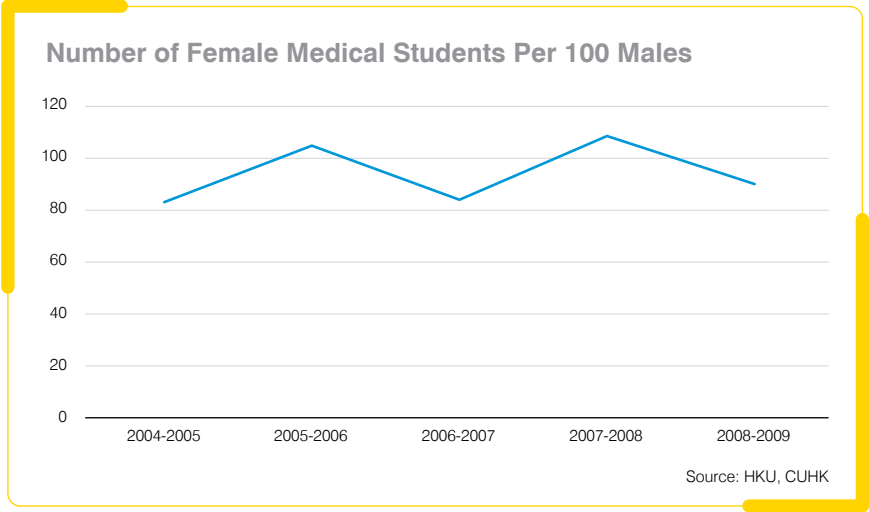


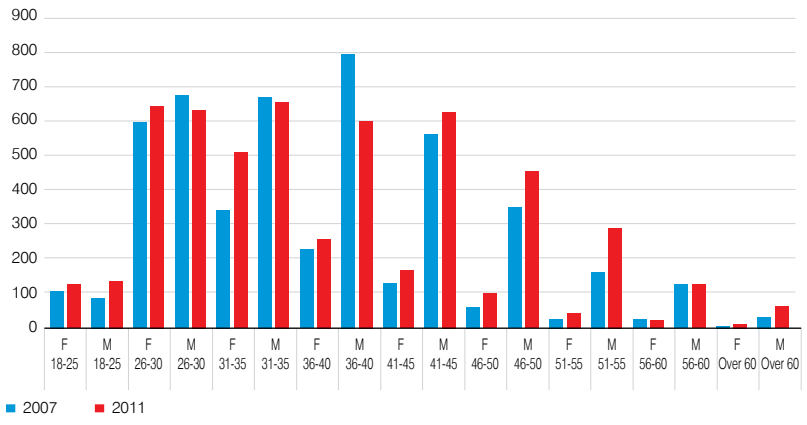


Our current workforce consists of 30% female doctors; more will retire at an earlier age, or work part time

Female doctors tend to retire earlier and switch to part-time more than their male counterparts. A survey by Women Doctors' Association shows that over 70% female doctors state that they are not spending enough quality time with their family, and 65% of female doctors wish to work 45 hours or less each week, while only a mere 10% are willing to work over 56 hours per week. As of today, close to 50% of medical graduates are female, which suggests that the total work hours of all doctors will decrease especially when female doctors hit their mid thirties. Between 2007 and 2011, 15% of the female doctors (c.100) left the HKHA system by the time they reached their early 30s, (12ppt more than the 3% men who leave the system).

As women especially have to juggle between taking care of family and work, it is understandable for them to opt for a more flexible work schedule in the private sector. Overseas research also suggests that female doctors carry less workload. An American Medical Association study revealed that on average, female doctors' total work hours are equivalent to 97.2% of male doctors. There are no official studies conducted in Hong Kong, but given so many more females quit the HKHA system after they have obtained a specialist recognition, it is reasonable to assume that female doctors in Hong Kong work even less than their American counterparts. Accordingly, the rising trend of more female doctors will continue to reduce the total number of doctor hours offered to our patients.

Doctors by Gender and Age in HKHA (2007 & 2011)



Source: HKHA

(2.5) Very high entry barriers for overseas qualified doctors: Between 2006-2010, only an average of nine overseas doctors (or 2% of annual new doctors intake) were added to the medical workforce each year

Currently, our supply of doctors is heavily reliant on local graduates, the annual intake of overseas qualified doctors remains at single-digit. Between 2006-2010, only an average of nine overseas doctors (or 2% of annual new doctors intake) were added to the medical workforce each year. Our current system requires overseas doctors to pass three Licensing Exams and complete a 12-month internship before they can attain full registration as medical practitioner in Hong Kong.

The Licensing Exams are held annually in Hong Kong and consists of three parts:

Part I: Examination in Professional Knowledge

Part II: Proficiency Test in Medical English

Part III: Clinical Examination

In theory, the Licensing Exams are a great method for screening subpar doctors from entering the Hong Kong market to ensure that we protect the quality of medical care. However, the Licensing Exams are criticised by many doctors due to the following reasons:

(1) Lack of transparency: Detailed syllabus and past exam papers are not readily available; candidates have to rely on word of mouth as to what subject areas form the knowledge to be examined when they prepare for the exams;

(2) Textbook/Technical/Impractical nature of examination questions: the Part I exam tests mostly textbook knowledge and includes questions that rarely appear in real-life clinical cases. Many experienced doctors have practised for years and cannot readily answer these questions because such knowledge is not required on their day-to-day clinical work. Many doctors have expressed that the exam is an out-of-date assessment and ineffective way to screen for competent doctors.

(3) Low pass rates: Pass rates of the licensing exams remained at 5-8% in the past five years. While it is debatable whether or not the level of difficulty is set too high, many local experienced doctors have expressed the view that they would fail the exams were they to take it today due to the impractically academic nature of the exams. As an analogy, it would be like examining a Nobel prize-winning molecular physics professor on O-level chemistry for his application to join the Institute of Nuclear Energy – even an over-qualified individual would not easily pass an exam that tests knowledge from his school days.

Pass Rates for Licensing Exams

Year	Number of examinees sitting in Examination Professional Knowledge (Part 1 of 3)	Licenses issued	% of successful candidates (estimated)
1999	165	16	10%
2000	132	10	8%
2001	124	10	8%
2002	104	7	7%
2003	76	9	12%
2004	77	7	9%
2005	81	10	12%
2006	105	5	5%
2007	117	8	7%
2008	138	9	7%
2009	158	12	8%
2010	168	11	7%

Source: HK Medical Council

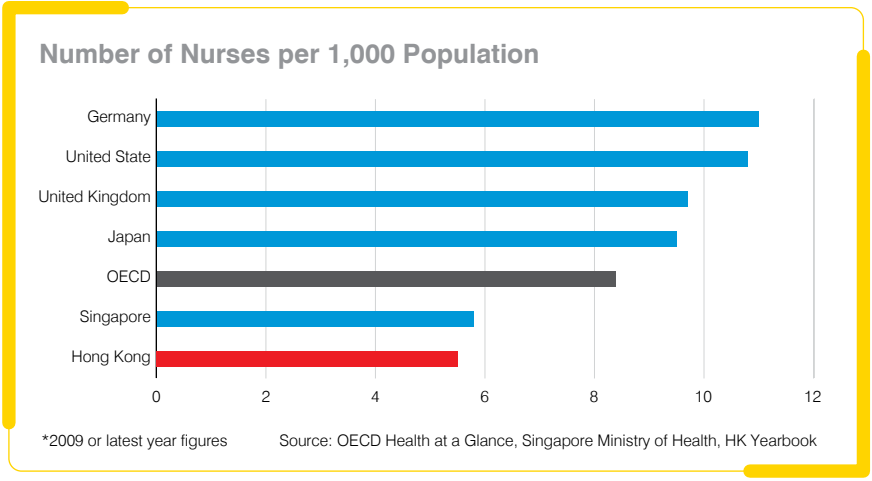
Loosening existing requirements will add c. 150 (or 1%) extra doctors each year

The existing system is rigid for scaling supply of specialists because the HKHA are limited to hiring from existing specialists in the market or the few overseas qualified doctors who have passed the three Licensing Exams and have completed the 12-month internship. Realistically, we are unable to cope with the decade-long lead time that is required to add capacity for our foreseeable increase in medical attention. Hence, the recruitment of qualified doctors from overseas is the most practical way for us to maintain the standards of our system. Management level doctors have estimated that Hong Kong can recruit c. 150-200 (or 1% of total doctors population) overseas qualified doctors per year if barriers were normalised.

(2.6) Insufficient support staff: Shortage in nurses, administrative staff etc. further burdens doctors' workload, and reduces efficiency of facilities and personnel

Doctors' supporting staff is in shortage as well

Nurses and allied healthcare professionals, as well as administrative staff are key supporters of doctors' work and crucial in providing quality medical services. However, nurses are similarly short in both the private and public sectors. With the closure of nursing schools between 1999 and 2008, the number of nurses trained each year dropped 76% from 1,391 to 336 each year. The total number of nurses working within HKHA saw a cutback by 5.6% from 20,435 nurses in 1999 to 19,273 in 2008, despite an increase in inpatients of 17% in public hospitals alone. The re-emergence of nursing schools in 2008 helped pick up speed in training nurses but the growth is not fast enough to compensate for the loss of manpower over the past decade. Consequently, the ratio of nurses to population dropped from 5.8 per 1,000 population to 5.4 within those nine years, which is significantly below the OECD average at 8.4. Despite efforts to train more nurses through nursing schools and associate degree programs in recent years, our nurses to population ratio (5.5 nurses per 1,000 population) remains dangerously low when compared to other developed countries (OECD average at 8.4) to the point that HKHA has admitted that it is still short of 1,000 nurses (c. 2.5%) even after spending HK$200m to recruit 1,600 nurses last year.

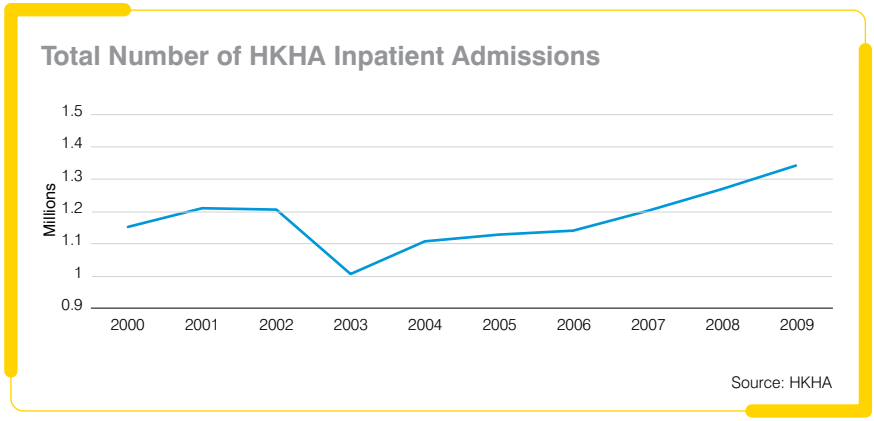


(3) Deficiencies in hospital facilities are worsening

(3.1) Stagnant public hospital facilities: Despite 6% growth in population and ageing of our population, 8% growth in inpatient admissions over the past decade, hospital beds grew by a mere 1% and zero hospitals were built when eight were established in the preceding decade; Public hospitals account for c. 80% of total inpatient numbers and c.75% of total hospital beds

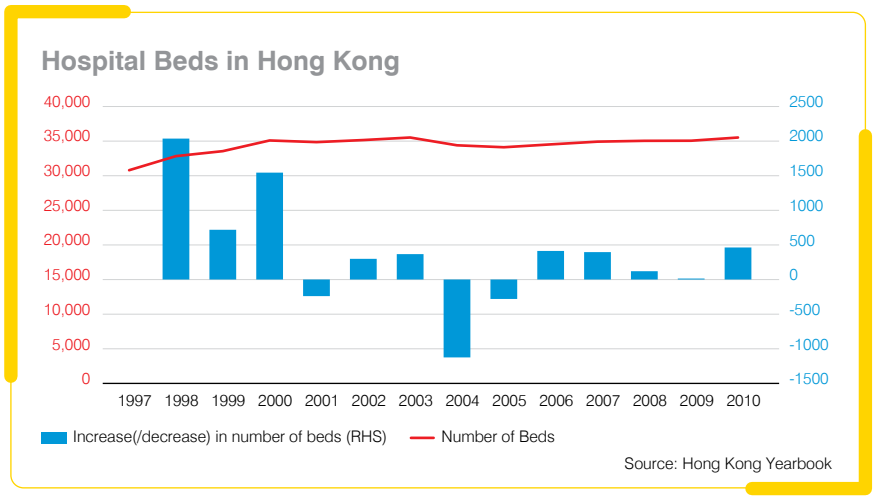
Hardware is deficient; zero hospitals built in our lost decade (2001-2010) when number of inpatients increased by 8%

For the past decade, our population grew by 5.5% (or c.380,000) and the number of hospital admissions in public hospitals increased by 8% (or c.90,000), yet our medical facilities have not been growing to keep pace with the increased demand and need for medical attention. The first decade of the 21st Century (2001-2010) of Hong Kong has been a "Lost Decade" in terms of hospital development – not a single new hospital came into operation, a stark contrast against the government's active engagement in constructing eight hospitals between 1990 and 2000. While there are plans for new hospitals in various locations, none of them will be fully operational until 2016.



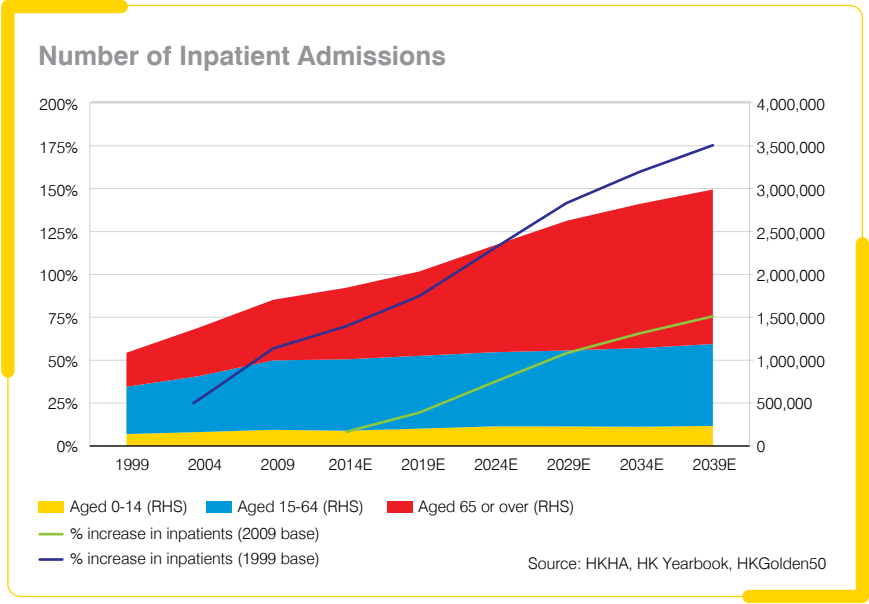
Hospital beds grew by a mere 2% and major hospitals are being stretched to limits

The number of beds has been stagnant from 2000 onwards. There were 34,860 hospital beds back in 2000, and the total number of beds grew by a mere 2% to 35,525 in 2010. Only 11 hospitals in the city hold over 1,000 beds, and three of them hold a c.90% occupancy rate. This is a dangerously high occupancy rate compared to global health standards that recommend a less than 85% occupancy rate on average. In emergency situations, the availability of beds becomes critical. The servicing capacity of beds in Tseung Kwan O Hospital, Princess Margaret Hospital and Tuen Mun Hospital has been stretched to the limits. These three hospitals in particular often have to set up temporary canvas beds as a band-aid policy to cater for the bed crunch, leaving patients to receive treatment and recover from their illness in cold corridors-- the shortage of beds has led to a decline in our quality of medical care.



Still no active planning from the Government's side— the two new key hospitals' reconstruction plans do not include adding new beds despite an increase of inpatients by 25-35% by the time the reconstruction projects are finished

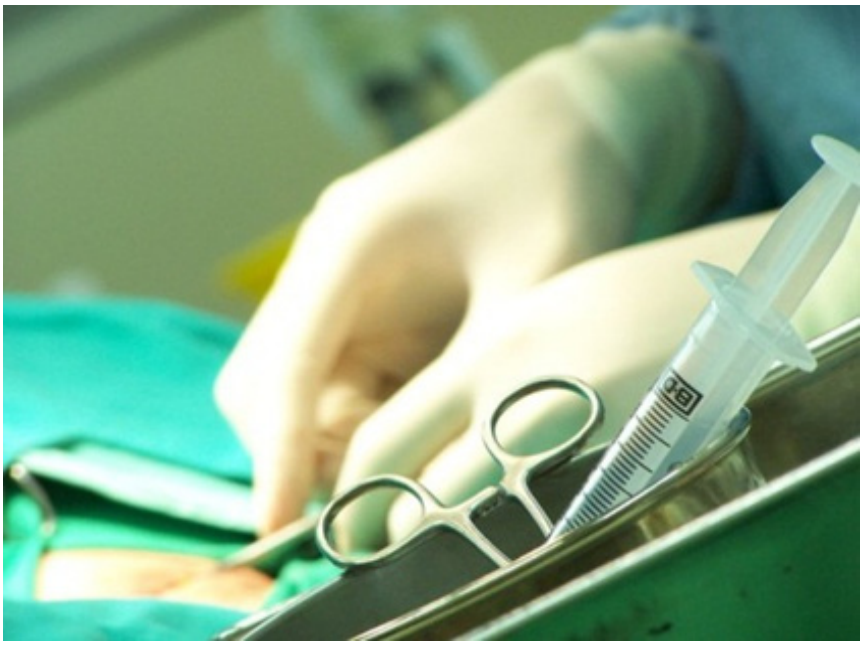
Many Hong Kong citizens have witnessed the alarming shortage of medical resources. The government has not responded sufficiently to our overstretched medical system with appropriate urgency. The two reconstruction projects at Queen Mary and Kwong Wah hospitals are not adding new beds to the system despite an increase of inpatients by 25-35% by the time the reconstruction projects are finished. It is certain that demand for beds will only increase when the projects are completed in 2020 and 2025 respectively; thus it is a lost opportunity to not increase number of beds as part of these reconstruction projects.



(3.2) Underinvestment in medical equipment: Budget cuts over the period 2000 to 2009 have caused severe hardware deficiencies; 36% of public medical equipment is over ten years old and is succumbing to technological obsolescence

36% of all medical equipment at public hospitals is over ten years old

Since the budget cuts for HKHA expenditure in 2000, many hospitals could no longer afford to replenish new equipment on a timely manner. Currently, 36% of all medical equipment at public hospitals is over ten years old. Medical facilities are not well-equipped to produce reliable and timely detection of diseases. Senior management doctors have pointed out that there are even times when hospitals have to turn down generous donors' offers to purchase new equipment, as their recurrent budget is insufficient to cover the maintenance cost of these equipment (c.20-30% of equipment cost). Many doctors have expressed concerns in replacing all equipment over 20 years old, yet their complaints and pleading requests were ignored, causing frustration and hurting staff morale.



Head of Surgery at Queen Mary Hospital Lo Chung Mau pointed out that medical equipment at public hospitals almost parallels that of third world countries. Medical equipment sometimes fall apart during operations, due to insufficient funding for maintenance and replacement. Dr. Ho Pak-leung, President of the Centre for Infection of HKU, also pointed out that almost 100% of the apparatus at the Centre for Infection are at least 20 years old. Facing a lack of adequate equipment, doctors often have to re-invent the equipment; for example, the UV-Light Box for rapid genetic testing/diagnosis at the Centre of Infection is “home-made” by the medical staff. While we appreciate innovation from the medical staff, Hong Kong is not so impoverished that we cannot replace such equipment. There are no excuses why we have to endure third world hospital facilities when our government has a HK$699bn fiscal reserve. Surely, life and death issues are worth investing in.

Life and death issues matter—HK$699bn fiscal reserve can prevent medical blunders induced by outdated medical equipment

(3.3) Growth of private hospitals is stunted by constrictive government policies: A quarter of incoming patients have to wait over ten days for available surgical theatres; Private hospitals wish to expand but government policies are restraining their growth

Growth in inpatients and hospital beds in private hospitals (2007/2011)

Private hospitals inpatients	2007	2011	Growth
Total	301,400	387,900	29%
Total, non maternity	270,530	337,565	25%
Local, non maternity	268,900	334,700	24%
Non local, non maternity	**13,500**	**20,200**	**50%**
Non-local, maternity	19,000	33,000	74%
Growth in private hospital beds	3,438	4,098	19%

Source: HK CSD, Ming Pao, Wen Wei Po, HKGolden50

Hardware is also lacking in the private sector

The waiting times to be admitted into hospitals are getting longer at Hong Kong's 13 private hospitals. On average, more than a quarter of incoming patients have to wait for more than ten days before their surgery can take place because no beds are available for them to be admitted into the surgical department. Many doctors, including top cardiologist Professor Lau Chu Pak sometimes need to turn away patients' requests for surgeries because doctors cannot guarantee bed spaces to perform surgeries on their patients in a timely manner. The 4,000 beds provided by private hospitals in total, representing 11% of total hospital beds in Hong Kong, are insufficient to accommodate for the imminent upsurge in inpatient demand. As mentioned in section 1.4, total inpatients in private hospitals increased by c.30% (7.5% p.a.) between 2007 and 2011, with a 50% increase in non local inpatients for non-maternity care.

Number of Inpatients in Public and Private Hospitals

Inpatients	2009	2010
HKHA hospitals	1,341,885 (79%)	1,423,705 (79%)
Private hospitals	361,563 (21%)	381,554 (21%)
Total	**1,703,448 (100%)**	**1,805,259 (100%)**

Source: HKHA, HK Yearbook

Distribution of Hospital Beds in Hong Kong (2009-2011)

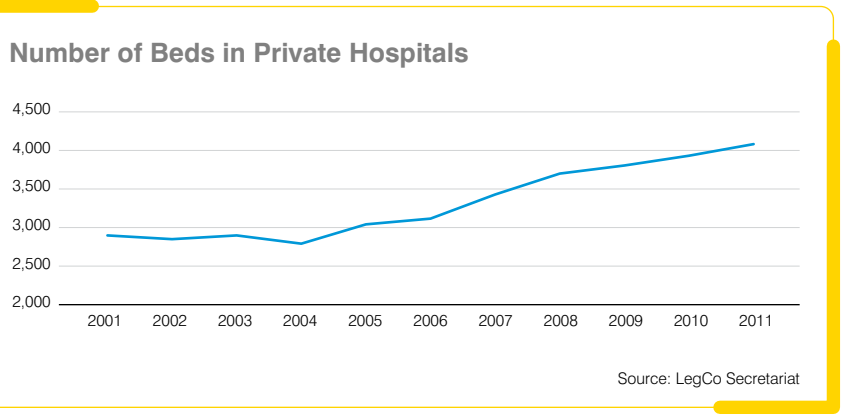
Total hospital beds	2009	2010	2011
Public hospitals	26,824 (77%)	26,981 (76%)	27,041 (75%)
Private hospitals	3,818 (11%)	3,949 (11%)	4,098 (11%)
Nursing homes	3,573 (10%)	3,803 (11%)	4,190 (12%)
Correctional institutions	799 (2%)	792 (2%)	792 (2%)
Total	**35,014 (100%)**	**35,525 (100%)**	**36,121 (100%)**

Source: HK Yearbook

Number of Beds in Public and Private Hospitals

Total hospital beds	2009	2010	2011
HKHA hospitals	26,824 (88%)	26,981 (87%)	27,041 (87%)
Private hospitals	3,818 (12%)	3,949 (13%)	4,098 (13%)
Total	**30,642 (100%)**	**30,930 (100%)**	**31,139 (100%)**

Source: HKHA, HK Yearbook



Source: LegCo Secretariat

Including hospital beds in correctional institutions and nursing homes, there are 36,121 hospital beds in Hong Kong in 2011. 14% are located in correctional institutions and nursing homes, 75% are in public hospitals, and 11% are in private hospitals

In private and public hospitals alone, there are a total of 31,139 beds in 2011. HKHA hospital beds make up 87% of beds

Compared with public hospitals, private hospitals are more responsive to the increasing demand for hospital care: total number of private hospital beds increased by 19% from 3,438 to 4,098 between 2007 and 2011 with the continuous expansion of private hospitals. However, the growth rate is still behind the 29% increase in private inpatients. However, more expansion works have been put on hold due to lack of space. Sanatorium hospital has been trying to increase its service capacity by building two 21-storey blocks to accommodate for a surge in medical demand, yet the project is still stalling due to limited space and government restrictions.

Private hospitals are reacting to market demand for more hospital care but shortage of expansion space remains a problem

Four sites for Private Hospital Development

Wong Chuk Hang

GFA: 2.5ha
Estimated capacity: 6-8 Floors

Tai Po

GFA: 2.6ha
Estimated capacity: 6-8 Floors

Tseung Kwan O

GFA: 2.2ha
Estimated capacity: 8 Floors

Lantau Tung Chung

GFA: 1.6ha (Private only) or 2.4ha (Private and public collaboration)
Estimated capacity: 8-9 Floors

Source: Food and Health Bureau

Plans to open new private hospitals are also in place. More than 30 bidders expressed interest in the four plots of land reserved for hospitals in Tai Po, Tseung Kwan O, Lantau and Wong Chuk Hang since 2009. However, talks are still in progress, leaving the four pieces of land idle for three years. The tender that came out in mid-April required bidders to offer at least 300 beds at each site by the second year of the hospital's operation. It is unlikely that the expected 5,500 beds to be provided by all private hospitals by 2017 can come in time with the delayed operation of these four hospitals. Accordingly, such delay will lower our medical care standards as medical demand cannot catch up with.

Four plots of land reserved for private hospital development have been put on hold for more than three years-- the government needs to speed up its process to alleviate the bottleneck problem in increasing demand for private healthcare

The proposed establishment of a private hospital in Clearwater Bay by 2014 remains delayed, as the original plan to house 300 beds is still under scrutiny by the Town Planning Board's strict plot ratio requirements. The hospital is now expected to offer a mere 235 beds, not enough to alleviate the shortage of beds in the cluster. According to global standards, a hospital cannot fully achieve economies of scale until they reach 300 beds. The restrictions in place should therefore be reconsidered, especially under the macro context where Kowloon East is under acute shortage of medical services. Such examples reveal inefficiencies of medical demand planning and how unreasonable the government is with respect to medical investment.

Originally planning to offer 300 beds to fully achieve economies of scale, Clearwater Bay Hospital can now only provide 235 beds under government restrictions