Development of Private Hospitals in Hong Kong: An Institutional Explanation

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Abstract

The development of private hospitals in Hong Kong has been sluggish. There has been no new private hospital for more than two decades. Despite complaints from private hospitals concerning unfair competition from the Hospital Authority, the sluggish development began at least a decade before the Hospital Authority was established. This paper argues that this phenomenon can be traced to three problems, including the lack of transparency and standardization of fee-charging, the variability of the quality of healthcare service, and the management problems related to corporate governance. However, these problems of private hospitals need to be further traced to the institutional environment that they are facing, characterized by government regulation which is minimal, and the fiercest resistance of the medical profession to any proposal of healthcare reform which appears to infringe its professional autonomy. The problems of private hospitals are a result of their adaptation to specific institutional environment. The case of the development of private hospitals in Hong Kong has broader theoretical implications for the study of institutional continuity and change. This paper argues that the sluggish development is a result of path dependence due to the coordination effect.

Keywords: private hospitals; institutions; path dependence; coordination effect

Introduction

The Hong Kong government proposed the Voluntary Health Insurance Scheme in order to alleviate the healthcare financing burden on tax. The viability of the Scheme depends on whether the capacity of private hospitals will increase significantly in order to meet the projected increase of demand after the implementation of the scheme. To gauge the future development of private hospitals, this paper reviews the development of private hospitals. Overall, the development of private hospitals can be described as sluggish. This paper offers an institutional explanation for this phenomenon. In particular, I argue that the sluggish development of private hospitals in Hong Kong is a typical case of path dependence due to the coordination effect. The case of the development of private hospitals in Hong Kong has broader theoretical implications that deserve attention from scholars who are interested in the study of institutional

continuity and change.

In the first part of this paper, I describe the sluggish development of private hospitals. In the second part, I trace the sluggish development to three problems of private hospitals of fee-charging, services and management. In the third part, I argue that the private sector faces a typical collective action dilemma characterized by the free-riding problem. While each private hospital may have incentive to overcome these problems of fee-charging, service and management, no hospital will take the initiative because of the expectation of punishment by the free-riding behaviour of other hospitals. The consequence is a tendency of the private healthcare sector towards inertia. In the last part, I offer a path-dependent explanation of the sluggish development of private hospitals in Hong Kong through highlighting the coordination effect. Actors adapt their strategies to a specific institutional environment in ways that reflect but also reinforce the tendency towards inertia. Exit becomes difficult without exogenous inputs.

Sluggish Development of Private Hospitals

The Hong Kong SAR Government proposed the Voluntary Health Insurance Scheme (自願醫保計劃) in 2014 (Food and Health Bureau, 2014). It was a response to a projected increase in healthcare expenditure in the coming decades. In the face of an ageing population and other related problems, the government expected an increase of demand for services from public hospitals. The purpose of the Voluntary Health Insurance Scheme was to facilitate a greater use of private healthcare services as an alternative to public services through enhancing the quality of health insurance in the market, so as to better enable the public sector to focus on providing services in its target areas. The proposal made clear that the implementation of the Scheme may require an increase of around 9% - 30% in capacity for private healthcare services over the next 10 years, and possibly up to 50% by 2036 (Food and Health Bureau, 2010, p. 36). So, the viability of the Scheme depends on the future development of private hospitals in Hong Kong.

There has been no new private hospital in Hong Kong for more than two decades. At present, there are 11 private hospitals. The latest was the Union Hospital founded in 1994. The second to latest was Hong Kong Adventist Hospital established in 1971. In other words, looking back from 2016, there is only one new private hospital in almost half a century.

Table 1: List of private hospitals in Hong Kong

Name of hospital	*Year of establishment*	*Location*
1. St. Paul's Hospital	1898	Hong Kong
2. Hong Kong Sanatorium & Hospital	1926	Hong Kong
3. Canossa Hospital (Caritas)	1929	Hong Kong
4. Precious Blood Hospital (Caritas)	1937	Kowloon
5. St. Teresa's Hospital	1940	Kowloon
6. Matilda International Hospital	1951	Hong Kong
7. HK Baptist Hospital	1963	Kowloon
8. Tsuen Wan Adventist Hospital	1964	New Territories
9. Evangel Hospital	1965	Kowloon
10. HK Adventist Hospital	1971	Hong Kong
11. Union Hospital	1994	New Territories

In terms of the number of beds, private hospitals provided 2,794 beds in 2004 (Table 3). Compared to the figure of 2,793 in 1988 (Table 2), private hospitals had almost literally no increase in capacity in 16 years. There appeared to be quite substantial increase in the number of beds since 2005. The figure in 2010 was 3,946. But the increase in the number of beds provided by private hospitals was apparently a response to the demand of pregnant mainland women. Moreover, the increase stopped in 2012, probably in response to the call for a stop by CY Leung, Chief Executive designate of pregnant mainland women giving birth in Hong Kong (Ming Pao 2012).

The viability of the Voluntary Health Insurance Scheme proposed in 2010 requires an increase of at least 9% in capacity for private healthcare services in 10 years. But the number of beds provided by private hospitals was 3,906 in 2014, indicating a decrease from 3,946 in 2010. However, the fundamental constraint to the capacity for private healthcare services lies in the number of private hospitals, not the number of beds. With no new private hospital, it would be difficult to imagine a significant increase in the number of beds because of the constraint of space. The dismal implication is that the Voluntary Health Insurance Scheme is likely to fail.

Table 2: Number of hospital beds, 1955-1988

Year	*Government hospital*	*Subvented hospital*	*Private hospital*	*Total*
1955	1,971	1,817	1,008	4,880
1960	2,432	3,771	1,108	8,090
1979	9,445	8,630	2,531	20,606
1980	9,684	8,585	2,537	20,806
1981	10,281	8,755	2,550	21,586
1982	10,743	9,222	2,725	22,690
1983	10,881	9,336	2,718	22,935
1984	11,759	9,578	2,736	24,073
1985	12,288	9,622	2,728	24,638
1986	12,285	9,601	2,664	24,550
1987	12,631	9,540	2,725	24,896
1988	12,687	9,577	2,793	25,057

Source: Director of Medical and Health Services, Annual Department Reports

Table 3: Number of hospital beds, 2001-2014

Year	*Public hospital*	*Private hospital*	*Total*
2001	29,243	2,903	32,146
2002	29,505	2,853	32,358
2003	29,539	2,902	32,441
2004	28,410	2,794	31,204
2005	27,765	3,038	30,803
2006	27,755	3,122	30,877
2007	27,748	3,438	31,186
2008	27,229	3,712	30,941
2009	26,872	3,818	30,690
2010	26,981	3,946	30,927
2011	27,041	4,098	31,139
2012	27,153	4,033	31,186
2013	27,400	3,882	31,282
2014	27,631	3,906	31,537

Source: Hong Kong Annual Digest of Statistics, 2012-2015

This paper tries to analyze the development of private hospitals. The primary focus is on the number of private hospitals. As mentioned above, there has been no new private hospital in Hong Kong for more than two decades. Also, there is only one new private hospital in almost half a century. The development of private hospitals has been sluggish. Even when we shift our attention to private hospital service, which is defined in terms of the number of hospital beds, the development has been unsteady, and the future development uncertain.

What explains the sluggish development of private hospitals in Hong Kong? Private hospitals often complain about unfair competition from the Hospital Authority. Healthcare services provided by the Hospital Authority through public hospitals are heavily subsidized by the government. The fee for accident and emergency (A&E) service is $100 per attendance. But the cost is $700. Every patient admitted to public hospital for in-patient service related to general acute beds will be charged $100 per day. But the cost is $3,290. In other words, the subsidization rate for both A&E services and in-patient services offered by public hospitals are 85.7% and 97% respectively (Information Service Department, 2011). In contrast, private hospitals do not receive any government subsidies. Therefore, the complaint from private hospitals is that they have been subject to unfair competition from public hospitals. Indeed, the market environment of private hospitals deteriorated in the 1990s after the Hospital Authority was founded in the 1990s. The market share of private hospitals shrank from 15% in 1991 to 7% in 1998 (South China Morning Post, 1998).

However, this complaint about unfair competition is misplaced. It can be established if the quality of service from public and private hospitals is comparable. But if the quality of service offered by public hospitals is poor, their cost advantage will be less significant. And the poorer the quality of service compared to private hospitals, the less significant will be the cost advantage. In this light, one should note that the quality of service from public hospitals was poor up to the 1980s. It was only in the 1990s after the Hospital Authority was formed that the quality of service improved dramatically (Leong, 1996).

Therefore, if the complaint of unfair competition is valid, the sluggish development of private hospitals should begin in the 1990s after the Hospital Authority was founded in 1990. However, there had been no new private hospital in the 1980s. Also, if one checks the number of beds offered by private hospitals in Table 2, the increase in the 1980s had begun to slow down. But during the same period, the increase of the number of beds offered by public hospitals, including government hospitals and subvented hospitals, was much more significant. In other words, the development of private hospitals became sluggish as early as in the 1980s. Even without the unfair competition from the Hospital Authority, the development of private hospitals had become sluggish. It is obviously insufficient to trace the challenge of private hospitals to the competition from the Hospital Authority.

Problems of private hospitals

I argue that the sluggish development of private hospitals can be traced to three problems, including the lack of transparency and standardization of fee-charging, the variability of the quality of healthcare service, and the management problems related to corporate governance.

Fee-charging

Regarding the problem of fee-charging, patients and their families often complain about the lack of standardization and transparency. The lack of standardization of fee-charging refers to the fact that patients and their families often do not know the charge until they are requested to settle the bill. The problem about transparency refers to the fact that they often do not know the charge in advance. According to a news report in 2014, the Department of Health received 43 complaints related to private hospitals. Among them, 35% were about fee-charging for services. During the same period, the Consumer Council also received 115 complaints about private hospitals, more than 60% of which were related to the lack of standardization of fee-charging. In one case, a patient complained that he was informed of the listed price for service at $10,000, but was charged $20,000 when he was discharged (Ming Pao, 2014).

The problem of the lack of standardization and transparency of fee-charging can be traced to the fact that the medical bill has two components. While one component is the charge for the use of facilities, the other component is the charge for services, including diagnosis and treatment, and the use of drugs. While the use of facilities can be determined in advance, the use of services and drugs cannot. From the medical point of view, every case concerning the illness of a patient is unique. Therefore, the complaint about the lack of standardization and transparency of fee-charging is ultimately a complaint about the doctor failing to communicate with patients about the matter of fee-charging.

The sluggish development of private hospitals has given rise to the problem of public-private imbalance in hospital care. David Fang, the former Director of St Paul Hospital, argued that the 'public-private imbalance is partly a result of the lack of transparency of private professional and hospital charges in HK' (Fang, 2006, p. 204). Leong Chi-hung, the former Legislative Councillor representing the medical sector, also opined that the government does not treat the Hospital Authority in any particularly favourable manner. The increase of funding through the 1990s was only on a par with the increase of government revenue because of the vibrant economy during the decade (Leong, 1996, pp. 10-12). There is no reason why the vibrant economy of the 1990s would not benefit the private hospitals at the same time. If the private hospitals had difficulty competing against the Hospital Authority, the problem about fee-charging is more likely to be the culprit.

Services

Another problem of the private hospitals is about the services they provide. Documentation and record-keeping about the illness of every patient is basic. This requirement of proper handling of medical records is also listed in a detailed manner in the Code of Professional Conduct of the Medical Council of Hong Kong. But the performance of private hospitals has not been satisfactory. In 2004, the Hong Kong Private Hospitals Association issued a joint statement by its members who represented all private hospitals of Hong Kong. The statement repeated the requirement to private doctors regarding the handling of medical records. Most important of all, the statement made clear that private doctors who did not fulfil the requirement would not be allowed to continue to receive cases from private hospitals.

The poor handling of medical records by private hospitals is related to the inordinately high ratio of visiting doctors. David Fang, the former Director of St Paul Hospital, admitted in an interview that his hospital once had 12 regular doctors and 1,000 visiting doctors (Hong Kong Economic Journal, 2007). The ratio of visiting doctors was exceedingly high. Obviously, the management of visiting doctors can be a challenge, including the effort to ensure that visiting doctors handle medical records properly.

Another problem about the service of hospital care is the dearth of outcome measures, such as complication rates, disease-specific mortality rates by hospitals and functional states of patients after treatment. To this extent, one has no evidence to judge the effectiveness of the medical treatment given. The Hospital Authority has made efforts to develop a more systematic collection of such data for the service of public hospitals.

Moreover, the quality of service of private hospitals is not a concern when the government renews their registration every year. At present, all private hospitals are required to go through the registration process before they have the legal status to provide medical services to patients. This requirement about registration comes from the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165). The Department of Health is in charge of the registration procedure. Also, all private hospitals have to renew their applications every year. They are required to fill out a questionnaire to report their operation in the previous year. This questionnaire is designed according to the Guide to Hospital Standards endorsed by the Medical Department Advisory Committee in 1990. But the Guide covers hardware issues mainly, such as facilities, equipment and the number of staff. It does not set any requirement about the standards of service, such as the complication rates and disease-specific mortality rates that are mentioned in the above paragraph.

Another aspect about services is patients' satisfaction. But private hospitals rarely conduct surveys on this issue. According to the Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes (Cap. 165 CoP), all private hospitals should

establish proper mechanisms to deal with complaints from patients. They also have to report to the Department of Health about the number of complaints, the details of the content and the results of investigation. However, this Cap. 165 CoP, unlike Cap. 165, has no legal status. So, the Department of Health has no legal power to enforce any rule or punish any hospital. Of course, it can investigate the complaint if it does receive information about the complaints. It can also request private hospitals to provide explanations about the complaints and the ways these complaints are handled. But the Department of Health does not disclose information about how it handles the complaints about private hospitals to the public on a regular basis.

Management

Private hospitals also suffer from a management problem. This management problem touches upon corporate governance, which refers to the mechanisms, processes, and relations by which corporations are controlled and directed. More concretely, it is concerned about the issues such as the composition of the governing board and committees, the terms of reference of these regular governing bodies, the rules and procedures which govern the daily operation of the organization, the identification of key performance indicators (KPIs), the preparation of annual business plans, and the submission of annual reports.

Again, the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) which provides the legal foundation for government regulation of private hospitals does not provide any specific requirement about how private hospitals should be managed. The most important requirement by the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance is that private hospitals should be registered. Decisions about registration by the Department of Health are based on conditions relating to the accommodation, staffing and equipment of the hospitals. But there is no further specification of criteria concerning the condition of accommodation, staffing and equipment, except that they are 'fit to be used' (section 3). For example, the hospital should be under the charge of a person who is 'a duly qualified medical practitioner' (section 3).

The Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) does not touch on management issues. For example, terminologies such as board and committee cannot be identified within the ordinance. A comparison with the Hospital Authority Ordinance (Cap. 113) is useful. The Hospital Authority Ordinance provides the legal basis for government regulation of how the Hospital Authority should be governed or managed. Besides the concern about accommodation, staffing and equipment, the Ordinance requires that the Hospital Authority shall 'improve the efficiency of hospital services by developing appropriate management structures, systems and performance measures' (section 4). The Ordinance also provides details about the establishment, functions and powers of committees by the Hospital Authority 'for the better performance of its functions and exercise of its power' (section 13 and 14). This part is totally missing from the Hospitals, Nursing Homes and Maternity Homes

Registration Ordinance (Cap. 165).

Before the millennium, many private hospitals were subject to a paternalistic model of management. The directors made all the management decisions, and they were not held accountable to any party within or outside private hospitals. Without systematic collection of information or regular exchange of views about management issues, it is no wonder that the management of private hospitals has lagged behind with time, and the public has gradually lost confidence. The situation became worse after the establishment of the Hospital Authority in 1990 as it dramatically improved the management of public hospitals.

After the Hong Kong Private Hospitals Association was established, the management of private hospitals began to improve. In 2000, it invited the Trent Hospital Accreditation Board to provide an accreditation service for private hospitals. Hospital accreditation is a measure used in many other countries to improve the quality of healthcare services and patient safety (Fang 2006, p. 205; Wong et al 2006, p. 489). In 2009, the Health and Food Bureau launched a Pilot Scheme of Hospital Accreditation in partnership with the Australian Council on Healthcare Standards (ACHS). The scheme encouraged participation from private hospitals as well as public hospitals. But the nature of the scheme was entirely voluntary. Until recently, not all private hospitals have participated in the Scheme. Obviously, the Hong Kong government intends to use accreditation as a tool to push private hospitals to improve the quality of its management and service. But the public is yet to see how far the accreditation can help.

To summarize, the sluggish development of private hospitals is a result of three problems, namely the lack of transparency and standardization of fee-charging, the variability of the quality of healthcare service, and the management problems related to corporate governance. These problems dampen the demand for medical services provided by private hospitals. In terms of the number of bed days, the market share of the private hospital was less than 10% for in-patient services in 2006 (Food and Health Bureau, 2008, p. 125). Such low market share makes the development prospect of private hospitals uncertain. It is no wonder that new investors hesitate to invest in this sector. It was only until the Individual Visit Scheme implemented after 2003 brought pregnant Chinese women to give birth in Hong Kong that local private hospitals began to increase the number of beds. Apparently, the further development of private hospital service in terms of the increase in the number of beds was less risky than the building of new private hospital because it involved a more flexible amount of investment.

Tracing the problems to institutional environment

In the face of keen competition from the Hospital Authority, private hospitals should have an incentive to resolve their own problems. But when they try to solve these problems, they face a typical dilemma of collective action. For example, when a private hospital wants to punish visiting doctors through prohibiting them from

continuing to receive cases because of their poor handling of the medical records of patients' illnesses, the visiting doctors may simply turn to other private hospitals for the referral of cases. On the other hand, a decrease of the number of visiting doctors may reduce the competitiveness of an individual private hospital because of the difficulty to continue to provide comprehensive services for patients. In other words, although all private hospitals have incentives to improve their handling of the medical records of patients, each is also tempted to take advantage of the efforts of other private hospitals to make improvements. Since all private hospitals expect the problem of free-riding, no one will take the initiative.

The root of the problem is the coordination of expectations, not the lack of incentives. There are only 11 private hospitals in Hong Kong. The interaction within the private sector is a typical example of strategic interaction because the actions of all private hospitals are interdependent. In this situation, what determines the choice of each private hospital is its expectation of the choice of others rather than its incentive (Schelling, 1980; Olson, 1965). Institutions are of critical importance to the effort to overcome the problem of free-riding because they can serve as both enforcement and coordination mechanisms. Firstly, institutions can help to resolve the problem through punishing individual actors who are free-riding on others. Secondly, institutions can serve to provide the focal point for expectations to converge. Actors are willing to cooperate when they expect others will cooperate too. Such convergence of expectations may arise from institutions. In other words, institutions can help to coordinate people's expectations and to this extent, overcome the dilemma of collective action (Shepsle, 1986, 1989; Weingast and Marshall, 1988; Garrett and Weingast, 1993).

Eventually, the Hong Kong Private Hospitals Association was formed in 2000 in order to explore the possibility of any collective effort to solve these problems. In 2004, it issued a joint statement repeating the requirement already stated in the Medical Registration Ordinance (Cap. 161) that doctors had the duty to handle the medical records of patients properly. Most important of all, the statement made clear that visiting doctors who did not fulfil the requirements would not be allowed to continue to receive cases from private hospitals. This is a typical example of the efforts of private hospitals to try to overcome the dilemma of collective action through collective effort.

But this is only a small step in a long journey. Other problems remain. Also, these problems of the private healthcare sector are a result of adaptation of private hospitals to their institutional environment. This institutional environment involves two aspects. The first aspect is about the government. The second aspect is about the medical profession. First of all, the lack of standardization and transparency about fee-charging, the variability of service quality and the inadequate management are all results of the lack of government regulation of the private healthcare sector. All private hospitals have to apply for registration from the Hong Kong government, and renew their applications annually in order to operate legally. The Department of Health (DH) processes the applications based on the Hospitals, Nursing Homes and Maternity Homes Registration

Ordinance (Cap. 165). But according to Audit Report No. 59 released by the Audit Commission in 2012, the DH has been rather passive in this regulation exercise. In the inspections of private hospitals conducted in 2011 and 2012, no checklist was used for documenting the inspection results. There was also no record readily available showing the extent of the checking performed. For some inspections in which serious irregularities were noted, the DH only provided summary reports of inspection to the hospitals concerned for follow up, but did not issue any advisory or warning letters to them (Audit Commission, 2012).

Since 2007, the DH has set up a sentinel event reporting system, under which all private hospitals are required to report a sentinel event to the DH within 24 hours upon the occurrence of the event and submit a full investigation report within four weeks upon occurrence of the event. Given the lack of statutory backing and the voluntary nature of the reporting system, under-reporting is likely to happen. Also, in many cases, the private hospitals concerned took a long time to report sentinel events or to submit full investigation reports to the DH. Notwithstanding this, the DH only issued three regulatory letters in respect of 55 cases of delays in reporting of sentinel events from 2008 to 2011.

To summarize, the government's attitude to regulating the private healthcare sector is passive. But the fundamental problem concerns the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165), which is very outdated. The Ordinance was enacted in 1966, which was already half a century ago. The Ordinance covers issues such as accommodation, staffing and equipment. But it does not touch on fee-charging, services or management. It stipulates a penalty of $1,000 on private hospitals for the contravention of regulations. Fifty years ago, such an amount might have been formidable. But today, it will not bother any private hospital. The lagging behind of government regulation of the private healthcare sector can be traced to the reluctance of the Hong Kong government to intervene. Social policy in Hong Kong has been described as 'pragmatic rather than principled' (Wilding, 2007), and the history of the healthcare system has been summarized as a story about expediency (Gould, 2006, p. 17). With no serious attention to the role and functions of private healthcare, and the appropriate institutional arrangement to steer the development of private hospitals along a certain direction, it is no wonder that private hospitals are gradually lagging behind.

Another aspect of the institutional environment that private hospitals are facing is the medical profession. The interests of private hospitals and the medical profession are not identical. In principle, private hospitals are not against government regulation. Since they are self-financed, they are primarily concerned about whether they can make their ends meet. They would welcome government regulation if they are confident that regulation will improve their business. In contrast, the medical profession is very sensitive about professional autonomy. All through the years, the medical profession has continued to appeal to professional autonomy when it questions the effort of the government to reform the healthcare sector. For example, to improve the

standardization and transparency of fee-charging, the government proposed packaged charging. But the implementation of packaged charging requires frontline doctors to follow a new set of procedures, which implies the increase of administrative workloads. This is the reason why the Hong Kong Medical Association representing the medical profession has shown fierce opposition to the implementation of packaged charging (Oriental Daily, 2011).

Since the colonial era, the Hong Kong government has preferred indirect rule when dealing with society. Regarding healthcare matters, the government has delegated the power of self-regulation to the medical profession through the Medical Council (Gauld and Gould, 2002, pp. 110-13). But in the face of a changing society with rising expectations about healthcare services, and the growing complexity of healthcare management because of rapid advancement of healthcare technology, the scope of self-regulation of the medical profession needs to be reviewed from time to time. But this runs against the understanding of the medical profession of its right to self-regulation in the first place. The more entrenched the understanding shared within the medical profession concerning professional self-regulation, the more reluctant the profession is to adapt to any reform which calls for the review of the scope of self-regulation.

I trace the sluggish development of private hospitals to outdated law and minimal government regulations. This is contrary to the free market perspective which argues for minimal government regulation. While I agree that the role of the government is to provide an environment conducive to economic development, a free market perspective is insufficient to inform the healthcare policy, particularly the development of private hospitals. A free market with minimal market entry is not enough. Investment in private healthcare sector may not be attractive. First of all, it is capital-intensive. For example, the Gleneagles Hong Kong Hospital, a new private hospital to be opened in 2017, requires a capital investment of approximately HK$5 billion. Second, the return on investment is uncertain. The former director of a private hospital described the investment in private hospital as a "black hole" in a personal conversation, meaning that one is never sure how much money he has to pour into running a private hospital. The fact of the matter is that of the four sites offered by the government for tenders in 2009 for the development of private hospitals, three were eventually scrapped as they received little interest during the tender period in 2013. Apparently, a free market is not enough to overcome the sluggish development of private hospitals. An appropriate institutional environment is needed to steer the development process.

Path dependence

The development of private hospitals has been sluggish for almost half a century. The sluggish development of private hospitals is a result of the institutional environment they are facing. To take a step further, I argue that the sluggish development of private hospitals is a result of path dependence (Luk, 2014, p. 138).

Path dependence refers to the phenomenon that the past matters in explaining the

present because exit from the institutional environment becomes difficult (Arthur, 1994; Thelen, 1999; Mahoney, 2001; Pierson, 2000; Pierson, 2004). What defines path dependence is not only the general argument that history matters, but also the specific argument that exit from the past becomes difficult (Pierson, 2000). Here, the institutional environment is understood as a legacy of the past.

Path dependence has been a prominent concept in social sciences in the last three decades (Arthur, 1989, 1994; David, 1985, 2000; Mahoney, 2000, 2001, 2002; Peters, Pierre and King, 2005; Pierson, 2000, 2003, 2004; Thelen, 1999, pp. 387-99). It emerged as a response to the mainstream approaches in social sciences, which tried to explain social phenomena as the end point of an inevitable and progressive process of change. The concept of path dependence departs from the idea that something happened in the past which locked social change into a distinct path to the present. But this path is just one among many other possible paths. In this sense, social change is marked by historical contingency rather than inevitability. Moreover, the concept of path dependence implies that the present may be suboptimal. But a more optimal scenario does not happen because social change has been path-dependent.

Path dependence can be traced to David's (1985) study of the QWERTY layout of typewriter and computer keyboard. He argues that there is no superiority of this layout from the technical point of view. It becomes entrenched only because it enjoys the advantage of being the first to the market. Future evolution of typewriter layout and computer keyboard is locked into a particular path, and exit becomes difficult.

To explain the difficulty of exit from historical legacy, Thelen distinguishes between distributional effect and coordination effect when she explains the reproduction of institutional order (Thelen, 1999, pp. 392-96; cf Ikenberry, 1994, p. 20). Distributional effect refers to the phenomenon that a certain institution tends to establish or codify a particular distribution of power and authority, which tends to reproduce itself. Institutions create "vested interests" that perpetuate the institution long after the original interests that created them are gone. However, the path dependence of the development of Hong Kong's private hospitals is not about the distributional effect because no party has any vested interest in the present system. As Yuen rightly observed, 'Everyone is unhappy about the current state of affairs. Public hospital patients are dissatisfied because of service quality deterioration. Front line healthcare workers in the public sector are dissatisfied because of their increased workload and reduction in pay, benefits and job security. Providers in the private sector face financial difficulties because of the lack of business' (Yuen, 2005, p. 462).

The path dependence of the development of Hong Kong's private hospitals comes from the coordination effect. Coordination effect refers to the phenomenon that once an institution is in place, actors adapt their strategies in ways that not only reflect how the institution operates, but further reinforce the institution.

Every private hospital may have incentives to change. But each expects other

private hospitals to be free-riding. The common expectations of all private hospitals about the problem of free-riding coordinate and reinforce the inertia and sluggish development of the private sector. The coordination of these expectations comes from the institutional environment that private hospitals are facing. As I have explained, this institutional environment is marked by the non-interventionism of the HKSAR government and the fierce resistance of the medical profession to government intervention. Through coordinating the expectations of all private hospitals, this institutional environment gives rise to the path dependent development of HK's private hospitals.

The explanation of path dependence in terms of coordination effect focuses on sunk cost. The latter refers to the efforts that private hospitals have already paid to adapt to the institutional environment. The cost is sunk because it is no longer recoverable. Although private hospitals are not happy with the environment, any change of this environment means that their previous effort to adapt will be wasted. Unless the return of the new environment is certain and significant, private hospitals will choose status quo. Stinchcombe describes sunk cost as liability of newness (Stinchcombe, 1965). Therefore, private hospitals have no incentive to seek change even though they do not find the existing institutional environment facilitating. They also expect other private hospitals to be lacking of incentive to change because they all face the same institutional environment. Path dependence based on coordination effect highlights the irony that actors are trapped by suboptimal reality.

Conclusion

To conclude, the development of private hospitals in Hong Kong has been sluggish. This sluggish development is traced to three problems of private hospital, including the lack of transparency and standardization of fee-charging, the variability of the quality of healthcare service, and the management problems related to corporate governance. But these problems of private hospitals are a result of their adaptation to the institutional environment they are facing. In particular, the sluggish development is a result of path dependence due to the coordination effect.

Ultimately, any break from the path-dependent development of private hospitals must come from a force powerful enough to revamp the institutional environment that the private hospitals in Hong Kong are facing. The effort of private hospitals to reform on their own through the coordination of the Hong Kong Private Hospitals Association is limited. In particular, any further attempt to resolve the problems of private hospitals concerning fee-charging and quality of service will touch upon the scope of the medical profession's autonomy. The impetus of reform must come from negotiation between the HKSAR government and the medical profession. Without any agreement between the government and the medical profession on the scope of professional autonomy of registered doctors, the prospect of healthcare reform in Hong Kong, including the development of private hospitals, will remain uncertain.

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