CHAPTER 4

Food and Health Bureau
Department of Health
Lands Department

Land grants for private hospital development

Audit Commission
Hong Kong
26 October 2012

This audit review was carried out under a set of guidelines tabled in the Provisional Legislative Council by the Chairman of the Public Accounts Committee on 11 February 1998. The guidelines were agreed between the Public Accounts Committee and the Director of Audit and accepted by the Government of the Hong Kong Special Administrative Region.

Report No. 59 of the Director of Audit contains 10 Chapters which are available on our website at http://www.aud.gov.hk

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LAND GRANTS FOR PRIVATE HOSPITAL DEVELOPMENT

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Executive Summary

1. Private hospitals are an integral part of the healthcare system in Hong Kong. It is the Government's policy to facilitate and promote private hospital development. As at September 2012, there were 11 private hospitals, five of which were operating wholly or largely on Government sites granted by private treaty (i.e. private treaty grants — PTGs) at nil or nominal premium. They were, namely Hospital B to Hospital F listed in Table 1 in PART 2 of this Audit Report. For these five hospitals, eight PTGs were involved and they together had provided some 1,950 hospital beds, which accounted for 49% of the hospital beds of all private hospitals. The Audit Commission (Audit) has recently conducted a review of the direct land grants made for private hospital development and has also examined one land sale transaction for private hospital development.

Special land grant conditions set on private hospitals

2. As early as 1957 and further elaborated in 1981, it was the Government's policy to grant Government sites by private treaty at nil or nominal premium to non-profit-making private hospitals, subject to a number of conditions. These conditions included the need to provide free or low-charge beds and the need to plough back profits/surplus derived from the hospitals to improve and expand the hospital facilities (i.e. the "Two Salient Requirements"). With the Government revenue foregone in terms of land premium, it was expected that a wider section of the public could be benefited. Audit however found that the Two Salient Requirements had not always been strictly and consistently applied on some of the direct land grants made. A PTG would normally last for 50 years or more. Audit noted that there had been a few opportunities to include the Two Salient Requirements (e.g. when the grantees applied for lease renewal, lot extension or lease modification to cope with hospital expansion or redevelopment) in the land grants, but the Administration had missed such opportunities.

Monitoring and enforcement of land grant conditions

3. Audit found inadequacies in the Government's monitoring and enforcement of the relevant land grant conditions, particularly the Two Salient Requirements. Specifically, Audit found that the requirement for the provision of free or low-charge beds imposed on three land grants for two private hospitals was not effectively enforced. For example, the Department of Health (DH) did not until April 2012 make any enquiry with Hospital D on the provision of the 20 free beds which had been imposed as a land grant condition since 1960's. The utilisation of the free beds ranged from 17% to 24% for 2007 to 2011, when the utilisation of the other beds ranged from 98% to 113%.

4. Whereas the "profits/surplus plough-back" requirement had been included in four PTGs for four private hospitals, Audit noted that in recent years, all four private hospitals on PTG sites had achieved surplus from their hospital operations. However, the DH had not on a timely basis adjusted its mode and degree of monitoring, and had not effectively monitored the hospitals/grantees' financial affairs to ensure their compliance with the requirement. For some of these hospitals, the sites were granted to their parent organisations, which then set up separate legal entities to operate the hospitals. Based on an examination of the hospitals' recent audited accounts submitted to the DH, Audit noted that significant hospital premises licence fees and donations had been paid by a few of the hospitals to the grantees, parent and/or related organisations. However, not until March 2012 had the DH inquired into the propriety of the licence fees and donations, or requested the grantees to submit audited statements of how the licence fees and donations had been accounted for.

5. Audit also noted that some hospital-related services (very often, in the form of specialist medical centres) were provided within the hospital premises on PTG sites by related companies. Given that such related companies were profit-making and maintained separate accounts from that of the grantees/hospitals, these might constitute subletting and profit-sharing arrangements by the grantees/hospitals with third parties, both of which might not be allowed under the land grant conditions.

6. Audit noted that the DH had made the following efforts: (a) in December 2010, the DH introduced a new measure of requiring the hospitals to submit auditors' certification on compliance with the financial-related land grant conditions; and (b) in March and August 2012, the DH had made enquiries on the various related party transactions reported in the hospitals' statements of accounts. Nonetheless, Audit considers that there is scope for improvement in better defining, and monitoring compliance of, the "profits/surplus plough-back" requirement in the land grants.

7. In June 2002, a lease modification was made to one land grant to allow Hospital C to operate on the PTG site a non-profit-making medical, health and welfare centre, which would provide, among others, a "social centre for the elderly" and a "day hospital with ... rehabilitation facilities". It transpired that the PTG site was used by Hospital C as a hospital block, providing 112 hospital beds and including 3-storey wards with first-class and second-class rooms. Audit could not find, based on Government records and site visits, that the "social centre for the elderly" or "day hospital with ... rehabilitation facilities" have been properly set up on the PTG site.

Sale of land for private hospital development

8. Land in Hong Kong is scarce and precious. Audit noted that at a hospital site of 1.922 hectares sold in 1982 by public tender for the development of a private hospital, only 54% of the site was used to operate Hospital G. The remaining 46% of the site was used to build a private residential development. The change in land use for the 46% was approved after some 20 years, and on the payment of a total land premium of $610 million by Operator G for the lease modification and land exchange in 2004. Looking back, the provision of 1.922 hectares at planning for the development of Hospital G might have been excessive. The land was planned and sold for building hospital facilities that could support a hospital with 600 beds. However, by setting a contractual requirement of only 200 beds (one-third of the maximum), coupled with the lack of appropriate development controls in the land lease, the Government's plan to fully utilise the entire site for the original purpose of hospital development was not realised. Audit considers that the Administration needs to draw lessons from this land sale transaction.

Way forward

9. Audit appreciates that the Government has recently developed revised policy, strategy and arrangements for future land disposals for private hospital development. In the advent of the Government's new approach to encouraging and supporting private hospital development, Audit considers that a proper system is needed to be put in place for the effective application and enforcement of the land grant conditions.

Audit recommendations

10. **Audit recommendations are made in the respective sections of this Audit Report. Only the key ones are highlighted in this Executive Summary. Audit has *recommended* that the Administration should take on board the audit observations and recommendations in this Report and improve the Government systems and procedures for coordinating, monitoring and regulating direct land grants made to non-profit-making private hospitals. More specifically, the Administration should:**

Special land grant conditions set on private hospitals

(a) **take appropriate steps to ensure that future policy decisions made on land grant conditions set on private hospitals are strictly and consistently applied, with approval sought from the Executive Council as necessary if deviations are required;**

Monitoring and enforcement of land grant conditions

(b) **put in place a proper mechanism and step up the Government's controls to monitor private hospitals' compliance with the land grant conditions, in particular the provision of "free or low-charge beds" and the "profits/surplus plough-back" requirement;**

(c) **require Hospital C to rectify as early as possible the various irregularities found on the land grant made for operating a medical, health and welfare centre (see para. 7 above); and**

Way forward

(d) **periodically assess the effectiveness of the stepped-up enforcement measures taken on existing private hospitals on PTG sites to ensure compliance with land grant conditions, and make any necessary adjustments as required.**

11. **Regarding the sale of land for private hospital development (see para. 8 above), Audit has also *recommended* that the Administration should draw lessons from the land sale transaction reported in PART 4 of this Audit Report and take actions to prevent recurrence.**

Response from the Administration

12. The Administration agrees with the audit recommendations.

PART 1: INTRODUCTION

1.1 This PART describes the background to the audit and outlines the audit objectives and scope.

Background

1.2 Private hospitals are an integral part of the healthcare system in Hong Kong. They provide primary healthcare services and a range of specialist and hospital services to members of the public who are willing to choose private services.

1.3 As at September 2012, there were 39 public hospitals (Note 1) and 11 private hospitals in Hong Kong, providing some 27,000 (87%) and 4,000 (13%) hospital beds respectively. According to the Administration:

(a) the Hong Kong healthcare system is heavily reliant on public hospitals, which provide over 90% of the in-patient services (in terms of bed-days) and their services are heavily subsidised (95%) by the Government;

(b) over the years, the situation in (a) above has resulted in an imbalance between the public and private sectors in hospital services, and has limited the competition and collaboration between the two sectors; and

(c) to meet the challenges posed by the ageing population and increasing demand for healthcare services, the Government needs to increase the overall capacity of the healthcare system in Hong Kong.

1.4 Various healthcare reform initiatives are also under policy consideration, including the proposed Health Protection Scheme under which participating insurers will be required to offer standardised health insurance plans providing the insured individuals with benefit coverage and reimbursement levels that will enable them to access general ward class of private healthcare services when needed.

Note 1: *All public hospitals are managed by the Hospital Authority with government subvention in accordance with the Hospital Authority Ordinance (Cap. 113).*

1.5 With a view to increasing the overall capacity of the healthcare system in Hong Kong to cope with the increasing service demand and to address the imbalance between the public and private sectors in hospital services, it is the Government's policy to facilitate and promote private hospital development. The Government is also aiming to rationalise the utilisation of private healthcare services and improve their efficiency, transparency and quality, with a view to enhancing the long-term sustainability of the healthcare system as a whole.

Private hospitals in operation

1.6 Most of the 11 existing private hospitals were founded decades ago. Some of them had purchased part or all of their sites from the market or through Government land sale. Six private hospitals were operating wholly or partly on Government sites granted or sold by private treaty. In the early days, because of the high capital outlays and long lead time involved, investment in private hospitals was rare. At that time, private hospitals were mainly built by religious and charitable groups, which were keen to provide health care for Hong Kong people. Land grants were often made by private treaty (i.e. private treaty grants — PTGs) at nil or nominal premium to the parent churches/corporations to encourage the establishment of the private hospitals which were not inspired by the profit-motive (Note 2). It was then considered that such non-profit-making private hospitals could help relieve the pressure on the government and subvented hospitals (now collectively termed "public hospitals" under the administration of the Hospital Authority — see Note 1 to para. 1.3). Because the social environment in Hong Kong in the early days was different from that of today, the land grant conditions were very simple, with some having no specified conditions. Private hospitals operated by religious and charitable groups have hitherto played an incontestable role in contributing to private hospital development in Hong Kong.

1.7 Recently, apart from supporting the expansion and redevelopment plans of existing private hospitals, the Government has also reserved four Government sites (reserved sites) for private hospital development. In April 2012, the Government put out the first two sites at Wong Chuk Hang and Tai Po for open tender. The

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Note 2: *As it transpired, the parent churches/corporations would usually set up member corporations to operate such private hospitals, with representatives from the parent churches/corporations sitting on the board of governors/directors of such member corporations overseeing the hospital operations.*

tender closed by the end of July 2012. It was expected that the result of the tender exercises would be announced in early 2013.

1.8 Private hospitals are regulated by the Department of Health (DH — Note 3) under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165 — the Ordinance). As the registration authority, the DH conducts hospital inspections, and monitors the private hospitals' compliance with the Ordinance. As at September 2012, 9 of the 11 private hospitals were charitable institutions which are exempt from tax under section 88 of the Inland Revenue Ordinance (IRO, Cap. 112 — Note 4).

Audit review

1.9 Land in Hong Kong is scarce and very precious. Land grants by private treaty, very often at nil or nominal premium, have in the past been made to encourage private hospital development. However, with the changes in the social and economic environment in Hong Kong in recent years, private hospitals today do make profits. It is an issue of public concern as to whether these private hospitals have been making proper use of the land granted at nil or nominal premium to serve the intended purposes, including benefiting a wider section of the public, and how the Government has monitored such direct land grants made. The audit scope covers the following two aspects:

Note 3: *Before April 1989, the licensing authority was vested with the then Director of Medical and Health Services and was transferred in 1989 to the Director of Hospital Services and in 1991 to the Director of Health, upon reorganisation of the former Medical and Health Department and the consequential establishment of the Hospital Authority and the DH. For simplicity, all references to the former Medical and Health Department (1966-89) and the Hospital Services Department (1989-91) and the existing DH since 1991 are referred to as the DH in this Audit Report.*

Note 4: *According to section 88 of the IRO, any charitable institution or trust of a public character shall be exempt from tax. Tax-exempt charitable institutions must be established exclusively for charitable purposes according to law. As required by the Inland Revenue Department, charitable institutions applying for tax exemption must have a governing instrument which states their objects precisely and clearly. For charitable institutions granted tax exemption, their incomes and properties may only be used for attainment of their stated objects and any distribution of their incomes and properties amongst their members is strictly prohibited.*

(a) a review of the direct land grants made by the Government at nil or nominal premium for private hospital development; and

(b) an examination of one land sale transaction for private hospital development. As it transpired, a significant portion of the hospital site had finally been used for private residential development.

1.10 The Audit Commission (Audit) started this review in March 2012 with fieldwork completed in September 2012. The review focused on the following areas:

(a) special land grant conditions set on private hospitals (PART 2);

(b) monitoring and enforcement of land grant conditions (PART 3);

(c) sale of land for private hospital development (PART 4); and

(d) way forward and audit recommendations (PART 5).

1.11 As a related review, Audit has also examined the Government's efforts in regulating private hospitals, and the results are reported in Chapter 3 of the Director of Audit's Report No. 59.

Acknowledgement

1.12 Audit would like to acknowledge with gratitude the full cooperation of the staff of the Food and Health Bureau (FHB), the DH and the Lands Department (Lands D) during the course of the audit review.

PART 2: SPECIAL LAND GRANT CONDITIONS SET ON PRIVATE HOSPITALS

2.1 This PART examines the special land grant conditions set on private hospitals which are operating wholly or partly on PTG sites. The audit issues and observations are discussed below.

Background

2.2 In general, the Government sells Government sites for purposes which are of general interest to the public, by public auction or tender to the highest bidder. However, Government sites are sometimes granted by private treaty to non-profit-making organisations at nil or nominal premium for special purposes, such as private hospital development. All such direct land grants have to be subject to stringent policy scrutiny and are thoroughly considered to be justified in the public interest, with specific approval granted by the Executive Council (ExCo) or by delegated authority exercised in accordance with the approved criteria set by ExCo, on a case-by-case basis.

2.3 In the past, it was the Government's policy to grant Government sites by private treaty at nil or nominal premium for non-profit-making private hospitals, subject to a number of conditions, including the following two salient requirements (hereinafter referred to as "Two Salient Requirements"), namely:

(a) the need to provide free or low-charge beds (with a requirement set in 1981 for providing "not less than 20%" of the total number of beds as low-charge beds); and

(b) there should be no distribution of profits/surplus, and profits/surplus (if any) derived from the hospital should be ploughed back for improving and expanding the hospital facilities.

These Two Salient Requirements were first discussed by ExCo in 1957 and in 1981 (see paras. 2.4 and 2.5). With conditions set on PTG sites granted to non-profit-making private hospitals, including these Two Salient Requirements, the Government intention was to forego the land premium, so that the lower investment cost of the private hospitals would benefit not only the patients who were able to pay higher charges but also a wider section of the public.

2.4 In April 1957, noting the then inconsistent practices adopted in direct land grants and the severe shortage of hospital accommodation, ExCo advised and the then Governor ordered that land should be made available for private hospitals in future on the following terms:

(a) where the site in question was so valuable that the Government was not prepared to forego any part of its value, it should be sold at auction with no restrictions on user; and

(b) for sites other than those in (a) above, land would be granted by private treaty to recognised non-profit-making charitable bodies and other welfare groups at nil premium, provided that:

  (i) free or low-priced beds and services to the satisfaction of the Director of Medical and Health Services (now the Director of Health) were guaranteed;

  (ii) there was no distribution of profits (accounts would have to be presented annually to the Government); and

  (iii) all profits were directed to the extension of the lessee's medical services.

Remarks: According to the 1957 Government records, all PTGs falling under (b) above would still require reference to the Governor in Council.

In 1959, because the Government required an assurance that "free or low-priced beds and services to the satisfaction of the Director of Medical and Health Services are guaranteed" (see (b)(i) above), the following requirements had subsequently been included as PTG conditions in one land grant made for the operation of a private hospital:

(a) provision of not less than 20 free beds in the said hospital;

(b) the requirement for the grantee to submit annual statements of the hospital to the then Medical and Health Department (M&HD — now the DH) on the total number of patients with breakdowns by first, second and third class paying patients and in-patients treated free; and

(c) the requirement for the hospital to be run in every respect and at all times to the satisfaction of the then M&HD (now the DH) which was provided with the right of access at reasonable times, for the purpose of inspecting the hospital.

2.5 In March 1981, ExCo advised and the then Governor further approved the Two Salient Requirements in more specific terms (Note 5). A full list of the 1981 requirements is provided at Appendix A. ExCo also directed that these conditions should form the basis of future PTGs for non-profit-making private hospitals. The Two Salient Requirements were specified in more elaborate terms, as follows:

Note 5: *At that time, ExCo was considering revisions to the conditions to be attached to a direct land grant at nil premium to a charitable organisation for operating a non-profit-making private hospital at Wong Chuk Hang. In the event, the organisation was unable to obtain the funds to develop the hospital and the site was returned to the Government in 1985.*

I. ***"Free or low-charge beds" requirement***

(a) Not less than 20% of the total number of beds provided should be low-charge beds;

(b) the daily maintenance charge for the low-charge beds was not to exceed the maximum of the third class scale in public hospitals; this was to cover bed, food and general services including nursing;

(c) other hospital charges like operating theatres, laboratory tests, X-ray tests, drugs, etc. were not to exceed 50% of similar charges applied to second class beds;

(d) by mutual agreement, the then Director of Medical and Health Services (now the Director of Health) might utilise any of the low-charge beds provided that the patients transferred were not chronic long-term cases and the Government would accept responsibility for the charges for these beds; and

II. ***"Profits/surplus plough-back" requirement***

(e) profits derived from the hospital to be directed towards improving the hospital facilities.

2.6 Once a policy decision has been made on the terms to be allowed for direct land grants to be made for private hospital development, it falls principally on the sponsoring bureaux and departments (B/Ds, i.e. the FHB and the DH for private hospital development) and the land authority (role now played by the Lands D — Note 6) to define the relevant land grant conditions to be included in the land leases entered into with the grantees and to enforce them. Close and effective coordination and cooperation among the three B/Ds, namely the FHB, the DH and the Lands D, underpins the successful implementation of the policy decision.

Note 6: *Until December 1981, the then Secretary for the New Territories was the land authority in the New Territories while the Director of Public Works was the land authority in the urban areas. With the re-organisation of the Government Secretariat in December 1981, the then Secretary for City and New Territories Administration became the land authority. Since its establishment in April 1982, the Lands D has been responsible for all land administration matters.*

2.7 More recently, in January 2011, ExCo further approved a new policy and strategy for future disposal of Government sites for new private hospital development. The four reserved sites mentioned in paragraph 1.7 would be disposed of in phases by open tender, and the new hospitals have to comply with a set of minimum requirements. Nonetheless, existing private hospitals on PTG sites will continue to operate on prevailing land grant conditions, until opportunities arise (such as lease modification to cope with hospital expansion or redevelopment) for reviewing the conditions. The more recent developments are discussed in PART 5.

Direct land grants to private hospitals

2.8 As mentioned in paragraph 1.6, among the 11 existing private hospitals, six were operating wholly or partly on Government sites granted/sold by private treaty decades ago. Because one site (LG 1) was sold by private treaty to Hospital A at market price, it was not examined in this review. Besides Hospital A, eight PTG sites (LG 2 to LG 9), with a total land area of some 26,000 m^2 (or 2.6 hectares — ha) mainly located in the urban areas, were involved in the operation of five private hospitals (Hospital B to Hospital F). As at September 2012, some 1,950 hospital beds, representing 49% of the 4,000 hospital beds provided by all private hospitals (see para. 1.3), were provided on the eight PTG sites. Details are shown in Table 1.

Table 1

Direct land grants made to five private hospitals

Private hospital	Land grant (LG) no.	Land premium	Minimum no. of hospital beds to be provided on LG site	No. of hospital beds provided on LG site (3 Sept 2012)
B	LG 2	Nil	40 to 45	60
C	LG 3	Nil	Not stipulated	759
	LG 4	Nil		112
D	LG 5	Nil		46
	LG 6	$1,000	500	625
E (Note 1)	LG 7	$5,000 plus surrender of another land lot	Not stipulated	176
F	LG 8	$1,000	300	174 (Note 2)
	LG 9	Nil	Not applicable (Note 3)	
Total				1,952

Source: DH and Lands D records

Note 1: It could not be readily ascertained from the Government records on how the site for Hospital E was first acquired. The hospital was established on a portion of LG 7.

Note 2: An additional hospital block on LG 8 was still under construction.

Note 3: LG 9 was granted to Hospital F for erecting staff quarters.

2.9 The five private hospitals in Table 1 were wholly or largely operating on PTG sites acquired at nil or nominal premium, as follows:

Hospital B, Hospital E and Hospital F

- They were operating wholly on PTG sites.

Hospital C

- It was operating primarily on LG 3 and LG 4 of 6,634 m^2 (see Appendix B). All 871 (759 + 112) hospital beds provided were on PTG sites.

- In 2007, the hospital also purchased land of 740 m^2 (LP 1 — see Appendix B) from the market with lease modification in November 2011 (at nil premium) for operating hospital services and providing not less than 102 beds on the site. As at September 2012, the hospital block on this site was still under construction.

Hospital D

- It was operating on LG 5 and LG 6 of 8,475 m^2 as well as self-purchased land of 3,255 m^2 (LP 2 — see Appendix C). 671 (64%) of 1,050 hospital beds provided were on PTG sites.

Two Salient Requirements as land grant conditions

Two Salient Requirements not consistently included

2.10 The Two Salient Requirements were set as early as 1957 and endorsed with more elaborate provisions in 1981 (see para. 2.3). An audit review of the eight land grants in Table 1 however indicated that the Two Salient Requirements were not always included in the direct land grants made to private hospitals as from 1957 at nil or nominal premium, as shown in Table 2.

Table 2

Two Salient Requirements in direct land grants made to private hospitals

Private hospital	Direct land grant			Two Salient Requirements	
	LG no.	**Effective time of grant of current lease (commencement of lease extension, where applicable)**	**Expiry time of current lease (Note 1)**	**"Free or low-charge beds" requirement**	**"Profits/surplus plough-back" requirement**
B	LG 2	June 1967	July 2038	×	✓
C	LG 3 (Note 2)	March 1982 (June 1997)	June 2047	×	×
	LG 4 (Note 3)	April 1981 (June 1997)	June 2047	×	✓
D	LG 5	February 1959	June 2073	✓	× (Note 4)
	LG 6	January 1996	June 2047	✓	✓
E	LG 7	March 1930 (June 1997)	June 2047	×	×
F	LG 8	June 2010	June 2060	✓ (see item (e) in Table 3)	✓
	LG 9	March 1965 (June 1997)	June 2047	Not applicable (Note 5)	

Source: Lands D and DH records

Note 1: According to the Joint Declaration 1984, all leases granted which did not contain a right of renewal and would expire before 30 June 1997, except short term tenancies and leases for special purposes, might be extended for a period expiring not later than 30 June 2047. Special purpose leases, including PTGs granted for hospital use, were extended individually, as appropriate.

Table 2 (Cont'd)

Note 2: The first PTG for this site was granted in 1958 which was surrendered in exchange for LG 3 in March 1982 to effect change of the grantee's name from Hospital C's parent organisation to Hospital C.

Note 3: Similar to LG 3, this site was granted to Hospital C's parent organisation in February 1980, but was surrendered in exchange for LG 4 in April 1981 to effect change of the grantee's name to Hospital C. Besides, LG 4 was granted not for providing in-patient hospital services, but for operating a medical, health and welfare centre (see para. 3.16).

Note 4: LG 5 originally contained a "profits/surplus plough-back" requirement, but was modified in 1983, as approved by ExCo in 1981, to the effect that there should be no distribution of profit derived from the hospital block on the site and the hospital could apply all such profits to charitable purposes of the grantee with the exception of any evangelical or ecclesiastical purposes (see Appendix C).

Note 5: Because LG 9 was granted for erecting staff quarters, it did not contain the Two Salient Requirements.

2.11 Table 2 shows the following anomalies:

(a) Hospital C, operating primarily on LG 3 and LG 4, was not obliged to provide any free or low-charge beds whereas Hospital D (provided with LG 5 and LG 6) and Hospital F (provided with LG 8) were obliged to do so;

(b) both Hospital C and Hospital D were obliged to plough back profits/surplus to hospital development for one of the PTGs made to them, but not for the other;

(c) LG 3 and LG 7 did not contain any of the Two Salient Requirements; and

(d) LG 2 and LG 4 contained the "profits/surplus plough-back" requirement, but not the "free or low-charge beds" requirement.

Opportunities to include the Two Salient Requirements not always taken

2.12 The policy decisions for the Two Salient Requirements to be imposed on future PTGs to private hospitals were made as early as 1957 and endorsed with more elaborate provisions in 1981. Audit however noted that although only a few direct land grants were made at nil or nominal premium in the past for private hospital development, the Two Salient Requirements had not always been strictly and consistently applied (see Table 2 in para. 2.10). Whilst it is practically difficult to trace the reasons why the Two Salient Requirements had not been included in some of the direct land grants first made in early years (as some of the records were not readily available), Audit noted that a few opportunities to include the Two Salient Requirements in the land grants had been missed, as shown in Table 3.

Table 3

Opportunities to include the Two Salient Requirements

Direct land grants made (effective year of grant)	Opportunities
(a) LG 2 to Hospital B (1967)	***"Free or low-charge beds" requirement*** • LG 2 did not contain the "free or low-charge beds" requirement because the DH informed ExCo in 1962 that the PTG should not require a percentage of free beds because "it has not been recent practice to require a percentage of beds to be free, but an assurance will be required that the majority of beds should be low cost". • Eventually, the PTG approved by ExCo included only the "profits/surplus plough-back" requirement, but not the "free or low-charge beds" requirement.
(b) LG 3 to Hospital C (1982)	***Both of the Two Salient Requirements*** • The PTG was due to expire by June 1997. In September 1994, the Government extended the then non-renewable lease (Note 1) for another 50 years to expire by June 2047, without taking the opportunity to revise the land grant conditions to incorporate the Two Salient Requirements (Note 2).
(c) LG 4 to Hospital C (1981)	***"20% low-charge beds" requirement*** • No such requirement was included in this PTG because the land was granted to the hospital not for providing in-patient hospital services. • As it transpired, LG 4 was providing in-patient hospital services. In 2008 when the hospital block on LG 4 commenced operation after redevelopment, the DH approved the hospital's application for providing 109 hospital beds under the Ordinance in the hospital block (see para. 3.21).

Table 3 (Cont'd)

Direct land grants made (effective year of grant)	Opportunities
(d) LG 7 to Hospital E (1930)	***Both of the Two Salient Requirements*** • LG 7 held by the grantee under a Government lease dated March 1930 was due to expire by June 1997. • In October 1993, the Government extended the non-renewable lease (Note 1) for another 50 years to expire by June 2047 (Note 2).
(e) LG 8 to Hospital F (2010)	***"20% low-charge beds" requirement*** • LG 8 was granted in June 2010 to the grantee in exchange for two replaced PTGs. With the land exchange, the grantee could expand Hospital F. • In this land exchange, the Government only stipulated a general requirement asking for the provision of "free or low-charge beds and services as when required by the Director of Health to his satisfaction", without specifying the "20% low-charge beds" requirement (see paras. 2.14 to 2.23).

Source: Lands D and DH records

Note 1: A non-renewable lease is a lease which does not contain a right of renewal. Upon expiry of the lease, the extension of such lease is solely at the Government's discretion.

Note 2: The Lands D informed Audit that it had then sought comments from the DH on the terms of the lease extension, but received no proposal from the latter to incorporate the Two Salient Requirements. On the other hand, the DH also informed Audit that:

(a) the Two Salient Requirements were not found in the draft of the terms prepared by the Lands D for the lease extension; and

(b) the Lands D then informed the DH that "It was intended that the leases would be extended on the existing conditions. … Only certain basic and essential conditions would be amended or inserted where there appeared to be serious defect in the existing lease. Mere updating of special conditions to accord with standard clause would not be incorporated …".

2.13 A PTG would normally last for 50 years or more. Opportunities to include the Two Salient Requirements may only arise when the grantee applies for lease renewal, lot extension or lease modification to cope with any hospital expansion or redevelopment. As such, the Administration should fully take such opportunities, and review and revise the land grant conditions as appropriate, including seeking approvals from ExCo if required.

LG 8 to Hospital F

2.14 LG 8 (see item (e) in Table 3) is a more recent example whereby the "free or low-charge beds" requirement had not been well defined in the land grant. In this case, the grantee submitted a land exchange proposal in 2008 to expand Hospital F. The proposal did not involve the granting of new pieces of land, but rather a land exchange with the granting of a new PTG substituting two PTGs previously granted in 1961 and 1965 and a change in land use for one of the replaced PTGs which was previously granted for the purpose of providing staff quarters and ancillary offices for the hospital.

2.15 In June 2010, LG 8 was granted to the grantee for a period of 50 years at a premium of $1,000. With the provision of LG 8, Hospital F, with an existing capacity of 174 hospital beds, was to be expanded to provide not less than 300 hospital beds. The Government had however not taken this opportunity to include or update the "20% low-charge beds" requirement in the new land exchange.

2.16 Although Hospital F was required under the land grant conditions to provide free or low-charge beds, LG 8 had not defined the number of such free or low-charge beds to be provided (such as "not less than 20% low-charge beds" as specified in 1981 — see para. 2.5(a)). As mentioned in item (e) of Table 3, the hospital was only required to provide free or low-charge beds and services "as when required by the Director of Health to his satisfaction".

2.17 On 22 June 2010, four days after LG 8 was executed, the DH issued a letter reminding Hospital F its obligation to provide free or low-charge beds and services as stipulated in the land grant conditions. However, the DH had again not taken the opportunity to elaborate in the letter the Government's expected requirements. There was also no evidence that since the execution of the new PTG

in June 2010, the DH had endeavoured to work out with Hospital F on how the "free or low-charge beds and services" requirement under the new land exchange was to be met, and how the Government would monitor the effective implementation of the requirement.

2.18 LG 8 had been effective since June 2010 and would last for 50 years or more. However, because it had not specified how the "free or low-charge beds and services", and the extent, were to be provided, the existing land grant provisions had left much leeway for the hospital to assign and use the beds at its sole discretion and in whatever way it deems appropriate (but subject to the DH's satisfaction). There was also no evidence that the Government had informed or sought approval from ExCo for the deviations from the 1981 requirements.

2.19 Based on FHB records, Audit noted that the exclusion of the "20% low-charge beds" requirement from LG 8 to Hospital F was a conscious decision made by the FHB in 2009, taking into consideration the following:

(a) no similar requirement, except LG 6 to Hospital D in 1996 (see Table 2 in para. 2.10), was found in other land grants made at nil/nominal premium to other private hospitals after 1981;

(b) although the Lands D suggested in its first draft of the land grant conditions to include the "20% low-charge beds" and other 1981 requirements (see para. 2.5(a) to (d)), the FHB took the view that because no material change to the scope of land use of the sites was involved, the land grant conditions in the replaced PTG, including the "free or low-charge beds" requirement, should be maintained;

(c) given that the purpose and effect of the new land grant (regarded by the FHB as a land exchange case) was in line with the original intent of the PTGs approved by ExCo in the 1960s, it was not necessary to seek ExCo's approval on the new land grant; and

(d) the Government was then in the process of reviewing the land policy including the land grant conditions for private hospital development (see para. 2.7). The review might result in changes to the "20% low-charge beds" requirement and the inclusion of other additional new conditions. The FHB further noticed during the review that practical difficulties were encountered in the implementation of the "20% low-charge beds"

requirement and in monitoring its compliance (Note 7). It was the Government's intention to abolish the "20% low-charge beds" requirement in future land grants which was to be replaced by other alternative requirements (such as packaged charge for the middle class), alongside other new conditions to ensure service quality (e.g. through hospital accreditation on a continuous basis and price transparency).

On the above grounds, LG 8 did not contain the "20% low-charge beds" and other 1981 requirements, but contained a more relaxed requirement (see para. 2.16).

2.20 Audit would like to point out that:

(a) the new land exchange had enabled Hospital F to increase bed capacity from the previous "not less than 130 beds" to "not less than 300 beds";

(b) in 2009 when the FHB decided to exclude the "20% low-charge beds" requirement from LG 8, approval from ExCo had not yet been obtained for the Government's new land disposal policy and strategy for private hospital development (see item (c) below). Therefore, ExCo's approval was required for the deviation from the 1981 requirement; and

(c) the fact that the "20% low-charge beds" requirement was difficult to enforce was not reported to ExCo until January 2011 after the Government's review of the new land disposal policy and strategy for private hospital development (see para. 2.7).

2.21 Nonetheless, Audit noted that on the FHB's request, LG 8 contained the following new "Compliance with prevailing policies" condition:

> "The Grantee shall comply with all requirements of the Director of Health arising from and relating to the Government's policies on private hospitals which shall or may at any time be in force in Hong Kong."

Note 7: *Although the DH was allowed under the land grant conditions to inspect the private hospitals at all reasonable times and to receive annual statements of the hospital bed occupancy (see items (h) and (i) in Appendix A), Audit found in this review that the DH had not effectively enforced the "free or low-charge beds" requirement, as detailed in PART 3.*

Because the DH had so far not imposed any additional requirements on Hospital F by using this new condition, how effective the condition can help enforce the Government's policies on private hospitals has yet to be tested.

2.22 As mentioned in paragraph 2.7, the Government formulated in January 2011 a new policy on future disposal of Government lands for new private hospital development. This included, inter alia, the decision that the Government would endeavour to replace the special condition for provision of low-charge beds included in land leases of existing non-profit-making hospitals by the minimum requirement of providing standard beds at packaged charges (which should cover doctors' fees, maintenance fees, diagnostic procedures, surgical operations, laboratory tests, X-ray tests, drugs and other miscellaneous items). According to the Administration, the provision of packaged charging would help enhance price transparency and provide incentive for patients to use private hospital services, and would benefit a wider section of the community and achieve a similar objective of providing low-charge beds.

2.23 Given that LG 8 has already been granted and Hospital F is in operation on LG 8 which was providing 174 hospital beds as at September 2012, Audit considers that the FHB and DH need to take early actions on the following:

(a) specify the Government's requirements clearly for provision of "free or low-charge beds and services" in Hospital F and explore whether the "low-charge beds and services" condition should be replaced by the 2011 minimum requirements (such as the provision of standard beds at packaged charges), taking into account the audit observations in PART 3 on the DH's enforcement of the land grant conditions;

(b) clarify the legal position on whether it is feasible for the Government to impose other additional requirements (such as the 2011 minimum requirements) on the operation of Hospital F through the use of the "Compliance with prevailing policies" condition available in the land lease (see para. 2.21); and

(c) putting in place a proper mechanism to monitor the effective implementation of the "low-charge beds and services" or "packaged charges" requirement in (a) and any other additional requirements imposed on Hospital F in (b) above.

PART 3: MONITORING AND ENFORCEMENT OF LAND GRANT CONDITIONS

3.1 This PART examines the Government's monitoring and enforcement of land grant conditions. The following audit issues and observations are covered:

(a) DH's compliance programme (paras. 3.3 to 3.9);

(b) provision of free or low-charge beds (paras. 3.10 and 3.11);

(c) profits/surplus plough-back requirement (paras. 3.12 to 3.15);

(d) site development not strictly in accordance with land grant conditions (paras. 3.16 to 3.29); and

(e) sub-leasing of hospital premises (paras. 3.30 to 3.38).

Government's land policy for direct land grants

3.2 As mentioned in paragraph 2.2, all PTGs made by the Government have to be subject to stringent policy scrutiny and are thoroughly considered to be justified in the public interest on a case-by-case basis, with specific approval granted by ExCo or by delegated authority exercised in accordance with the approved criteria set by ExCo, and upon the support of the sponsoring B/Ds. Once a PTG has been made, subsequent developments must conform to the land grant conditions. Normally, the sponsoring departments (e.g. the DH in this case) monitor, and control where appropriate, the facilities and services operated/developed on the site with their support. They will consider matters according to the relevant land grant conditions under their purview and liaise with the Lands D as necessary in enforcement. They will work closely with the Lands D and take steps to ensure that the PTG sites are properly and continuously used for designated purposes, and the land grant conditions are properly complied with.

Department of Health's compliance programme

3.3 The DH is vested with the power to regulate private hospitals under the Ordinance (see para. 1.8). Each year, it conducts at least one annual inspection and one ad-hoc inspection of each hospital. Apart from ensuring the hospitals' compliance with the Ordinance, the DH also has a role to play in ensuring the hospitals' compliance with the land grant conditions, including the Two Salient Requirements and other requirements, such as the requirements for the hospitals to submit annually audited statements of accounts and statements of the hospital bed occupancy to the DH (see items (b), (f), (g) and (i) in Appendix A). To enable the DH to monitor the proper operation of the hospitals on the PTG sites, the DH is permitted to inspect the hospitals at all reasonable times and to request the hospitals to provide any other information relating to their operations as may be required (see items (h) and (j) in Appendix A).

Inadequacies in DH's compliance checking

3.4 To monitor the private hospitals' compliance with the land grant conditions, Audit would expect the DH to have maintained a proper checklist on the land grant conditions which each private hospital should comply with, and to regularly bring up the checklist for compliance checking. Audit however found that such a compliance checklist was not maintained. Even with the DH's annual hospital inspections conducted in more recent years, apart from ascertaining the hospitals' progress in providing the low-charge beds (only applicable to Hospital D and Hospital F — see Table 2 in para. 2.10), there was no documentary evidence to show that the DH staff had checked the hospitals' compliance with other land grant conditions, such as taking steps to identify any suspected sub-leasing activities and to verify the use of those free or low-charge beds. The DH had only stepped up its efforts in recent years, as follows:

(a) since December 2010, introducing a new arrangement of requesting private hospitals to submit, when applying for hospital re-registration, the hospital auditors' compliance certifications, i.e. certifications confirming that the hospitals had complied with all the financial-related requirements in the land grant conditions; and

(b) since March 2012, seeking clarifications with private hospitals on donations made as reported in their statements of accounts submitted.

3.5 Table 4, using Hospital D for illustration, shows examples of such land grant conditions that required the DH's regular monitoring and the DH's compliance checking, if any, that had been performed. It had so far not issued any advisory or warning letters to private hospitals on non-compliances detected.

Table 4

Examples of land grant conditions applicable to Hospital D

Relevant land grant conditions	DH's compliance checking
For LG 5 (effective since 1959):	
(a) The grantee shall provide not less than 20 free beds in the said hospital.	The DH had not made any enquiry until April 2012. In May 2012, the hospital submitted statistics of free bed cases from 2007 to 2011 to the DH (see para. 3.11(a)).
(b) The grantee shall submit annually to the DH a statement giving details of the total number of first, second and third class paying patients treated, and the number of in-patients treated free.	There was no evidence that the grantee had annually submitted such bed occupancy information to the DH. Similar to item (a) above, the hospital submitted such statistics from 2007 to 2011 in May 2012 to the DH.
(c) There shall be no distribution of hospital profits derived from the said hospital. All profits, if any, derived from the said hospital shall be applied to charitable purposes of the grantee with the exception of any evangelical or ecclesiastical purposes.	The DH annually received audited statement of accounts from the hospital, but had not raised any queries on the accounts except: (i) introducing, in December 2010, a new arrangement of requesting private hospitals to submit for 2012 hospital re-registration the auditor's certification confirming compliance (see para. 3.6); and (ii) making an enquiry in March 2012 on the "donations paid" as reported in the accounts for 2009 and 2010 (see para. 3.13(b)).

Table 4 (Cont'd)

Relevant land grant conditions	DH's compliance checking
For LG 6 (effective since 1996):	
(d) Not less than 20% of the total number of beds provided in the said hospital at any time shall be low-charge beds.	The hospital auditor confirmed for the first time in August 2011 that the hospital had a standing policy of making available 100 beds (approximately 20% of the total number of beds available) as low-charge beds (see para. 3.6).
(e) The Grantee shall inform the DH of details of all fees to be charged and any subsequent amendments to the fees to be charged for all medical services (Note) to be provided by the said hospital not less than once every six months.	Hospital D only submitted information on its room charges schedule to the DH annually when applying for hospital re-registration. It had only reported the fees charged (at daily rate of $100 per bed) for the low-charge beds since 2010.
(f) There shall be no distribution of profit derived from the said hospital. All profits, if any, derived from the said hospital shall be directed to the improvement or extension of the Grantee's hospital facilities.	Similar to item (c) above

Source: DH records

Note: According to the DH records, such medical services shall include, but not limited to maintenance, consultation, treatment, laboratory tests, X-ray tests, emergency services and other ancillary facilities.

3.6 In December 2010, the DH introduced a new measure by requesting private hospitals to submit, when applying for hospital re-registration, auditors' certification confirming that the hospitals had complied with all the financial-related requirements in the land grant conditions. This applied to hospital re-registration for 2012 when the hospitals submitted their applications in 2011. Audit noted that all five private hospitals on PTG sites (see Table 2 in para. 2.10) had submitted the auditors' certifications for their 2012 hospital re-registration. Audit welcomes the DH's initiative, but considers that there is scope for improvement in the DH's arrangement for seeking auditors' certifications.

3.7 In particular, Audit noted that the DH had not defined in its requests to the private hospitals the specific financial-related requirements which individual hospitals needed to comply with. As a result, the auditors' certifications so submitted by the private hospitals in 2011 could not provide adequate assurance that individual hospitals had properly complied with all the financial-related land grant conditions. Without specifying clearly the requirements, the auditors' certifications might fall short of the DH's expectations. This is evident from the following inadequacies noted from the auditor's certification submitted by Hospital D in August 2011:

(a) The auditor confirmed that the hospital had a standing policy in 2010 of making available 100 beds as low-charge beds for LG 6, but there was no mention of the hospital's compliance with the provision of "20 free beds" requirement on LG 5.

(b) The auditor confirmed that the hospital did not make any profit distribution in 2010, but the auditor's certification had not mentioned:

  (i) whether there had been any profit deployment for "evangelical or ecclesiastical purposes" for LG 5 which was not allowed; and

  (ii) whether profits/surplus gained from LG 6 had been properly ploughed back for hospital improvement or extension.

3.8 In May 2012, the DH informed the Lands D for the first time that it noted from the recent statements of accounts submitted by three private hospitals on PTG sites that they had made donations from the hospital accounts, and sought the Lands D's advice on whether the statements of accounts of the three hospitals were consistent with the respective land grant conditions. In July 2012, the DH further sought clarification from the Lands D on the application of the "profits/surplus plough-back" requirement in the land grants to the whole hospital or to only those parts of the hospital on PTG sites. In mid-September 2012, the Lands D provided the DH with its advice and as at late October 2012, the DH was following up the matters.

3.9 Given the various inadequacies noted in the DH's compliance programme, Audit considers that the DH needs to put in place a proper mechanism to monitor the private hospitals' compliance with the land grant conditions. This includes, inter alia, the following:

(a) compiling a checklist on land grant conditions to be complied with by the private hospitals;

(b) setting up a proper "Bring Up" system to conduct regular checking;

(c) improving the auditors' certification system by defining/specifying the financial-related land grant conditions to be confirmed by the hospital auditors; and

(d) expanding the DH's compliance programme to cover other relevant land grant conditions.

Provision of free or low-charge beds

3.10 As shown in Table 2 in paragraph 2.10, three land grants (namely LG 5, LG 6 and LG 8) made to two hospitals (Hospital D and Hospital F) contained the requirement for the provision of free or low-charge beds, as follows:

Hospital D

(a) **LG 5** provides that "The grantee shall provide not less than 20 free beds in the said hospital.".

(b) LG 5 has further provided that Hospital D should furnish annually to the DH a statement giving details of the total number of first, second and third class paying patients treated, and the number of in-patients treated free *(based on the DH's correspondence with Hospital D, patients on such free beds should be treated free, i.e. without charges)*.

(c) **LG 6** provides that:

"Not less than 20% of the total number of beds provided in the said hospital at any time shall be low-charge beds.

The daily maintenance charge for such low-charge beds which covers beds, food and general services including nursing, shall not exceed the maximum of the third class scale in Government hospitals (Note). Other hospital charges for such low-charge beds, such as charges for operating theatres, laboratory tests, X-rays tests and drugs, shall not exceed 50% of similar charges applied to second class beds of the said hospital.

The Director of Health may, by mutual agreement with the Grantee, utilise the low-charge beds provided that:

- the patients using such beds shall not be chronic long term cases; and
- the Government shall pay the daily maintenance charge and the other hospital charges (if any) for such beds as stipulated .....".

Hospital F

(d) **LG 8** provides that "The Grantee shall provide free or low-charge beds and services as when required by the Director of Health to his satisfaction.".

Note: As at September 2012, the Hospital Authority was charging patients of third-class beds at $100 per day.

Free and low-charge beds requirement not effectively enforced

3.11 Audit noted that the free and low-charge beds requirement in the land grants was not effectively enforced, as elaborated below:

Provision of free beds in Hospital D on LG 5 (see para. 3.10(a) and (b))

(a) free beds should have been provided by the hospital on LG 5 since the 1960's. However, although the land grant had stipulated that the hospital should furnish annually to the DH a statement indicating the total number of first, second and third class paying patients treated, and the number of in-patients treated free, Audit found that there was no reporting of these statistics. The DH did not make any enquiry until April 2012 when Audit questioned whether the 20 free beds had really been provided. In the same month, the DH also enquired the Lands D on whether the "20 free beds" requirement was still in force. In May 2012, the Lands D confirmed in the affirmative. In the same month, the hospital also informed the DH of the following regarding the provision of 20 free beds:

(i) the utilisation of the free beds from 2007 to 2011 ranged from 17% to 24% (Note 8);

Note 8: *The utilisation rates were low, as compared with those of other regular beds available in the whole hospital for the years 2008 to 2011 (ranging from 98% to 113%).*

(ii) such free beds were provided to patients in the form of charity with a social worker assessing the cases (including interviewing the patients and completing assessment forms), taking into consideration of various elements (Note 9). There had been no written policy so far as regards the percentage of fee concession. The rule was the consideration by the social worker of waiving of fee ranging from bed charge only, bed charge plus part of the hospital expenses/doctor fee, to the entire hospital bill in full (i.e. bed charge, all medical expense and doctor fees); and

(iii) the free beds were provided at different places (i.e. dispersed in different hospital blocks) and the hospital had not designated any particular ward or bed class for such beds (Note 10).

Provision of not less than 20% low-charge beds in Hospital D on LG 6 (see para. 3.10(c))

(b) Hospital D should have provided not less than 20% of the total number of beds provided on LG 6 as "low-charge beds" since late 2002 after the

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Note 9: *Based on information provided by the hospital to the DH in May 2012, the social worker would consider essentially the following elements in deciding the percentage of fee concession to be granted to individual patients:*

(a) family income;

(b) family saving/assets;

(c) financial condition (e.g. mortgage and loans, other financial commitment such as education and old age support);

(d) number of family members to support;

(e) unexpected rise in medical expenses (e.g. unexpected treatment expenses arising from treatment complications);

(f) social financial assistance; and

(g) availability of medical insurance protection.

Note 10: *The land grant has required that the free beds should be provided in the hospital block on LG 5. In a site visit to Hospital D in September 2012, accompanied by DH staff, the hospital informed Audit that it still had not designated any particular ward or bed class for free beds.*

commencement of operation of the hospital block on the site (Note 11). However, based on the DH's records, Audit noted that the hospital only started to work on meeting the "low-charge beds" requirement in 2008. In May 2008 at which time the hospital was providing 561 hospital beds, it made a request to the DH for the provision from June 2008 onwards of 20 low-charge beds initially (instead of 20% low-charge beds) and for increasing the number when the need arose. In early October 2009, in paying its annual inspection to the hospital, the DH revealed that only 58 low-charge beds were provided. Following media reports in mid-October 2009 about the hospital's failure in providing an adequate number of low-charge beds, the hospital informed the DH in late October 2009 that 100 low-charge beds had been provided. In turn, the FHB/DH informed the Legislative Council in November 2009 that the hospital had fulfilled the requirement for the provision of 100 low-charge beds in October 2009. In another annual inspection to the hospital in December 2011, the DH further found that equipment and consumables had not been set up or were not readily in place in one of the wards providing low-charge beds. Based on a site visit to Hospital D in September 2012, accompanied by DH staff, Audit was informed by the hospital that 98 hospital beds had been designated as "low-charge beds" in the hospital block on LG 6;

(c) given that the hospital was providing 625 hospital beds on LG 6 (see Table 1 in para. 2.8), it should have provided not less than 125 (625 × 20%) low-charge beds at any one time. However, Audit noted that the DH had taken the view that 124 nursery cots for well babies should not be taken into account in calculating the 20%, on the grounds that such nursery cots were provided in conjunction with the obstetric beds at no extra charge for obstetric packages. Given that the land grant condition has stipulated that the total number of beds provided should be used as the basis for calculating the 20% (see para. 3.10(c)), the interpretation of this requirement would need to be worked out and agreed between the DH and the Lands D;

Note 11: *The land grant has required the hospital block on LG 6 (with low-charge beds) to commence operation on or before 25 January 2000. With several extensions to the commencement date for operation, as approved by the Government, the hospital block commenced operation in late 2002.*

(d) since 2008, the hospital has started to report the utilisation of low-charge beds to the DH. Based on the information reported, the low-charge beds had very low utilisation rates (1% in 2008 and ranging from 23% to 45% during 2009 to 2011), as compared with 98% to 113% of other regular beds available in the whole hospital. There was however a drastic increase in the low-charge bed utilisation rates reported by the hospital following the media reports in 2009 (see item (b) above). Nonetheless, there was no evidence that the DH had attempted to verify the reported utilisation rates (Note 12);

(e) the land grant conditions have required that other hospital charges (such as operating theatres, laboratory tests and X-rays tests) provided by the hospital should not exceed 50% of similar charges applied to second-class beds of the hospital. Following the media reports, the DH conducted an inspection in December 2009 and found that the hospital notice at the admission counter for low-charge beds was too small to read. The DH also examined the hospital bills for two discharged cases to ensure that they complied with the land grant conditions. In December 2010, the DH requested the hospital to confirm its compliance with all the financial-related land grant conditions (see para. 3.6). In its certification of August 2011, the hospital auditor reported that, on the basis of general auditing work and selective statistical sampling of the charges for the year 2010, certain expensive drugs for such low-charge beds were charged at cost that exceeded 50% of similar drugs charged to second-class bed patients. No follow-up action was taken by the DH;

(f) although the DH was obliged under the land grant conditions (see para. 3.10(c)) to enter into mutual agreement with the grantee on how to use the low-charge beds, no such agreements had been entered into with the hospital and no procedures had been laid down for referring patients, say from the Hospital Authority, to Hospital D. In January 2012, Hospital D informed the DH that patients should meet the following criteria for admission to the low-charge beds:

Note 12: *During a site visit to Hospital D in September 2012, accompanied by DH staff, it was noted that in calculating the utilisation of the 98 designated low-charge beds, the hospital had incorrectly included the usage of 11 other beds (designated for Haemodialysis Services) in the usage of low-charge beds, but such 11 beds were not included in the denominator. As a result, the reported utilisation rates could have been inflated. The DH staff had on the spot instructed the hospital to correct the errors.*

(i) they must be Hong Kong permanent residents holding valid Hong Kong Identity Cards;

(ii) they should have an admission letter from the hospital's resident doctor or a visiting doctor; and

(iii) those in possession of a medical insurance policy would also be entertained.

However, the DH did not confirm if the above criteria were acceptable. With the low utilisation rates of the low-charge beds reported by the hospital since June 2008 (see item (d) above), there was no evidence that the DH had taken any effective measures to optimise the use of these beds, including consulting the Hospital Authority (which is always known to be facing an acute shortage of hospital beds);

Provision of low-charge beds in Hospital F on LG 8 (see para. 3.10(d))

(g) in the replaced PTG granted to Hospital F in 1961 (superseded by LG 8 in June 2010 — see paras. 2.14 and 2.15), the grantee was also required to provide free or low-priced beds and services to the satisfaction of the DH. There was however no evidence that the DH had agreed with the hospital on the number of such free or low-priced beds to be provided. Neither was there any reporting by the hospital of the provision or utilisation of such free or low-priced beds on the replaced PTG to the DH;

(h) in 2008, the DH made an enquiry on how Hospital F had fulfilled its obligation to provide low-priced beds and services as laid down in the land grant conditions of the replaced PTG. In its reply, Hospital F informed the DH that:

(i) "the hospital imposed a daily charge of $500 to $550 for each bed in the 6 to 7-bed rooms. The charge was not sufficient to cover the costs of its ward services"; and

(ii) "as a complement to Hospital Authority's services, the hospital provided significant discounts to the Authority's referred patients requiring diagnostic tests."

The DH had apparently accepted the hospital's explanation as it did not pursue further. Audit however noted that the daily charge of $500 to $550 for such low-priced beds provided by Hospital F was much higher than that charged by Hospital D for its low-charge beds (at $100 per day);

(i) similarly, after the execution of the new PTG (LG 8) in June 2010, there was no evidence that the DH had worked out with Hospital F on how the "free or low-charge beds and services" requirement in LG 8 was to be met and how the Government would monitor the effective implementation of the requirement (see para. 2.17); and

(j) in its annual return submitted to the DH in November 2011, the hospital reported for the first time that it had provided 33 low-charge beds in its Surgical Unit and Medical Unit. No information was however provided on their utilisation. Up to August 2012, there was also no evidence that the DH had verified the availability of low-charge beds in its annual and ad-hoc inspections to the hospital.

Profits/surplus plough-back requirement

3.12 For the following four PTG sites granted at nil or nominal premium to four private hospitals, the land grants have laid down the conditions that the grantees should not distribute the profits/surplus derived from the hospitals and should direct such profits/surplus towards improving the hospital facilities (i.e. a "profits/surplus plough-back" requirement):

(a) LG 2 to Hospital B;

- *Grantee:* parent organisation of Hospital B
- Hospital B is operating wholly on LG 2.

(b) LG 4 to Hospital C;

- *Grantee:* Hospital C (see Note 3 to Table 2 in para. 2.10)
- Hospital C is operating primarily on LG 3 and LG 4 (see para.2.9). LG 4 contains "profits/surplus plough-back" requirement, but not LG 3.

(c) LG 6 to Hospital D; and

- *Grantee:* parent organisation of Hospital D
- Hospital D is operating on LG 5 and LG 6 as well as self-purchased land (see para. 2.9).
- LG 6 contains a "profits/surplus plough-back" requirement whereas LG 5 does not. LG 5 has however required that there shall be no distribution of profits derived from the said hospital and that all such profits shall be applied to charitable purposes of the grantee with the exception of any evangelical or ecclesiastical purposes (see Appendix C).
- The self-purchased land contains no restriction on distribution of profits.

(d) LG 8 to Hospital F.

- *Grantee:* a related organisation of Hospital F
- Hospital F is operating wholly on LG 8 and LG 9.
- LG 8 contains a "profits/surplus plough-back" requirement, but LG 9 (for staff quarters) does not.

Profits/surplus plough-back requirement not adequately enforced

3.13 Audit noted that in recent years, all these four private hospitals on PTG sites, although operating in non-profit-making mode, had achieved surplus from their hospital operations. However, despite the changes in their business environment, the DH had not timely adjusted its mode and degree of monitoring. In particular, with significant surplus being achieved by a few of these private hospitals, the DH had not effectively monitored the hospitals/grantees' financial affairs to ensure their compliance with the "profits/surplus plough-back" requirement in the land grants. Based on an examination of the hospitals' recent audited accounts submitted to the DH (Note 13), Audit noted the following:

(a) ***Payment of rentals/licence fees to grantees.*** For Hospital B and Hospital F, the grantees had allowed the hospitals to operate on LG 2 and LG 8 on a rent-free/nominal rent basis. For Hospital D, a licence agreement was entered into annually between the grantee and the hospital to allow the latter to operate within the hospital premises on both the PTG sites (LG 5 and LG 6) and the self-purchased land. Licence fees, payable at terms determined and agreed between the two parties, were charged as "Operating lease — hospital premises licence fee paid" against the hospital's surplus each year and reported as "Related party transactions" in the Notes to the accounts. Audit is concerned with the inclusion of such related party transactions in the hospital's accounts which would have the effect of reducing the hospital's surplus available for ploughing back for the hospital's use, unless the grantee had also submitted separate audited accounts to show how it had disposed of the licence fees that related to LG 5 and LG 6. However, not until late August 2012 had the DH requested the grantee to submit such accounts. As a result, the DH had not adequately enforced the "profits/surplus plough-back" requirement on the land grant. There were complications in that Hospital D was operating on both PTG sites as well as self-purchased land, and only LG 6 contained a "profits/surplus plough-back" requirement. Given that the licence fees paid by Hospital D to the grantee were significant (see below), Audit considers that the DH needs to take early actions, in consultation with the FHB and the Lands D, to follow up with the submission of the grantee's audited accounts for LG 5 and LG 6;

Note 13: *Copies of such accounts should also have been filed by the private hospitals with the Companies Registry in accordance with the Companies Ordinance (Cap. 32) and are therefore available for public access.*

Hospital D: Hospital premises licence fees paid

1. For 2009 and 2010, the hospital had paid licence fees of $303 million to the grantee, representing 22.7% of the hospital's surplus for the two years. Until Audit made enquiries, there was no evidence that DH had clarified with the hospital on details of the licence fees paid and how the grantee had disposed of the fees received.

2. On Audit's enquiries with the DH in July 2012, the grantee provided the DH with copies of the annual licence agreements for the use of the hospital premises it entered into with the hospital. There was no breakdown in the licence agreements of the licence fees payable for PTG sites and for self-purchased land.

3. Based on an examination of the DH records, Audit noted that as early as the 1970's, the DH had once queried certain financial transactions in the hospital's accounts (e.g. advances made by the hospital to the grantee — Note) and, after correspondence with the hospital auditor and with adjustments made, accepted that the hospital was operating on a non-profit-making basis and within the terms of the special conditions of the land grant. However, the DH did not appear to have stepped up its monitoring of the hospital's finances in respect of such related party transactions.

4. On the DH's enquiries in late August 2012, the grantee submitted in late September 2012 to the DH an unaudited financial summary for the income it received over the years 2006 to 2010 from the operation of Hospital D, including the hospital premises licence fees it received from the hospital (see para. 3.14).

Note: In a letter of February 1978, the DH informed the hospital that whilst non-profit-making did not preclude the making of a gross profit, any profits arising from the daily operation of a hospital must be devoted exclusively to the purposes of the hospital and not to any other purpose whatsoever. The DH also urged the hospital to pay back any advances made to the hospital's accounts.

(b) ***Donations made to parent/related organisations.*** To fulfil the "profits/surplus plough-back" requirement in the land grants, profits/surplus arising from the daily operation of a hospital must be devoted exclusively to hospital improvement or extension. By the same

token, any donations (especially of substantial amounts) made by the hospitals to the grantee and/or parent/related organisations out of surplus derived from services provided on the PTG sites with the "profits/surplus plough-back" requirement should be justified and reasonable. Audit noted that three private hospitals, namely Hospital C, Hospital D and Hospital F, had made donations to the grantee and/or parent/related organisations. However, the DH did not make any enquiries with the hospitals/grantees on the donations until March 2012 (see below). Furthermore, the DH had not clarified with the Lands D on the propriety of hospitals' donations of substantial amounts made to the grantee and/or parent/related organisations until May 2012 (see para. 3.8). Details of the hospitals' donations made and DH actions taken are as follows:

Donations made by private hospitals

Hospital C

1. LG 3 to Hospital C does not contain a "profits/surplus plough-back" requirement whereas LG 4 does. The hospital had made a donation of $5 million in 2009 to a related company which was set up in 2009 as a non-profit-making company for promotion of charitable activities. On DH's enquiry in March 2012, the hospital indicated that the donation was made in accordance with its Memorandum of Association and that the donation would help promote and support charitable work for the public and improve image in the community.

Hospital D

2. Hospital D is operating on LG 5, LG 6 and self-purchased land, and only LG 6 contains a "profits/surplus plough-back" requirement.

3. According to Hospital D's audited accounts of 2009 and 2010, the hospital had made donations of $180 million in the two years to "companies with common directorship". The amounts were based on "terms determined and agreed between the hospital and the related parties" and represented 13.5% of the hospital's surplus for the two years.

(Cont'd)

4. In March 2012, the DH made its first enquiry with the grantee on the donations made, and enquired whether they were made for the purpose specified in LG 6. The DH also asked the grantee to provide supporting documents certified by an auditor.

5. In April 2012, the grantee informed the DH that the donations were made by the hospital to it. It further informed the DH, among others, that money paid to it by the hospital had been applied to the improvement or extension of the hospital facilities as well as other charitable purposes, notably on education and for the needy, i.e. they were "dedicated to education, the care of the sick and the underprivileged".

6. In early September 2012, the DH informed Audit that it would further clarify with the grantee on how the income the latter received from Hospital D, including donations and licence fees, would be used for the hospital facilities and charitable purposes (except for evangelical or ecclesiastical purposes) and seek documentary evidence from the grantee. In late September 2012, the grantee provided the DH with an unaudited financial summary for the income it received over the years 2006 to 2010, including donations, from the operation of Hospital D (see para. 3.14).

Hospital F

7. Hospital F is operating wholly on LG 8 and LG 9, and only LG 8 contains a "profits/surplus plough-back" requirement.

8. According to the hospital's audited accounts submitted, the hospital had paid donations of $22.8 million to a related organisation of the grantee in 2009 and 2010. The donations, representing 12.8% of the hospital's surplus for the two years, were "determined by the board of trustees" and, as explained by the hospital, both the related organisation and the hospital have common trustees.

9. In response to the DH's enquiry in March 2012, the hospital informed the DH that making donations to the related organisation was allowed under the object clause of its Memorandum of Association.

(c) ***Provision of hospital-related services in the hospital premises by profit-making related companies.*** Audit noted that some hospital-related services (very often, in the form of specialist medical centres) were provided within the hospital premises on PTG sites by related companies. Such companies were related to the grantee, the hospital or both. They were profit-making and maintained separate corporate existence and accounts from the grantees/hospitals. Profits derived by these companies were not included in the hospitals' profits/surplus (except dividends on investments) and had the effect of reducing and redistributing profits/surplus made by the private hospitals on PTG sites. There was however no evidence that the DH had clarified with the FHB and the Lands D on the propriety of such business arrangements entered into by the hospitals/grantees and whether the operation of such medical centres on PTG sites would constitute subletting (see para. 3.38(a)) or fall under the operational responsibility of the hospitals. Two examples are shown below:

Profit-making medical centres in operation on PTG sites

Hospital B

1. The hospital had allowed a profit-making associated company (31.2% owned by the hospital) to operate within its hospital premises on LG 2.

2. Investments in the associated company of $3.2 million were classified as an asset in the hospital's accounts, with income earned in the form of "Share of profit in an associated company" and "Dividend received" included as investment income in the hospital's accounts.

3. On DH enquiries in August 2012, Hospital B informed the DH in late August that the hospital entered into a joint venture with a group of registered medical practitioners in 2006 to set up a specialist medical centre on the ground floor of the hospital premises. In order to secure adequate funding, a limited company was formed with 28 shareholders.

4. Over the past six years, the company had distributed dividends three times. As informed by the hospital in late August 2012, it had ploughed back its share of the profits (after taxation) from this joint venture to the general funding of the hospital to support hospital running and development.

(Cont'd)

Hospital D

5. The hospital had allowed a number of related companies to provide hospital-related services within the hospital premises on PTG sites and self-purchased land.

6. Based on DH records and company search, Audit found that such related companies were primarily owned by the grantee, with a small percentage of the shareholding held by the hospital and by registered medical practitioners. Taking one related company as an example, 70% of the shares were held by the grantee and 10% by the hospital. Income was received from such related companies by both the grantee and the hospital in the form of "licence fees" and "dividends".

7. On the DH's enquiries in late August 2012, the grantee submitted in late September 2012 to the DH an unaudited financial summary for the income it received over the years 2006 to 2010 from the operation of Hospital D, including dividends it received from such related companies operating on PTG sites (see para. 3.14).

(d) ***Sub-licences entered into by the hospital with third parties, including related companies.*** As mentioned in item (a) above, for Hospital D, the grantee (the parent organisation) entered into a licence agreement annually with the hospital which was required to pay licence fees to the grantee. On the other hand, Audit noted that the hospital had further entered, as licensor, into sub-licences with third parties, including the related companies in item (c) above, for use of certain areas of the hospital premises on PTG sites and self-purchased land for the provision of hospital-related services. The hospital received sub-licence fees from such sub-licensees, and in 2010, licence fee income of some $18.3 million was recorded in the hospital's accounts. Audit is concerned whether such sub-licences entered into by the hospital with the third parties, including the related companies in item (c) above, are permissible for the PTG sites under the existing land grant conditions. There was however no evidence that the DH had consulted the Lands D or raised any questions on their appropriateness under the land grant conditions;

(e) ***Submission of one set of audited accounts.*** Hospital C, which is also the grantee, submitted one set of audited accounts to the DH for the whole hospital which operated on two PTG sites. However, LG 3 where three hospital blocks were sited and providing 759 hospital beds, contains no "profits/surplus plough-back" requirement whereas LG 4, with one hospital block and providing 112 hospital beds, contains such a requirement. The DH had not enquired how the hospital would split its hospital surplus between LG 3 and LG 4, but consulted the Lands D in August 2012 on how to apply the "profits/surplus plough-back" requirement, i.e. whether it should be applied on each of the land lots of Hospital C or on the hospital as a whole. Based on the Lands D's advice in September 2012, the requirement should apply to the land lot in question only; and

(f) ***Submission of draft accounts.*** In the case of Hospital F, for the years 2009 and 2010, the hospital submitted each year to the DH only one set of draft audited financial statements (unsigned) covering two hospitals (namely Hospital F and its sister hospital not in operation on PTG sites) and a nursing school. LG 8 to Hospital F contains a "profits/surplus plough-back" requirement. The DH had not urged the grantee/hospital operator to submit properly signed audited accounts for the two years, nor had it enquired how the grantee/hospital operator would split its profits/surplus among the two hospitals and the nursing school. In August 2012, Audit noted that the hospital had provided the DH with copies of the signed audited financial statements covering the two hospitals (i.e. Hospital F and its sister hospital) for the year 2010 and an audited revenue and expense summary statement (certified by the hospital auditor in August 2012) for Hospital F for the five years of 2006 to 2010.

3.14 Given that the scope of this audit is confined to reviewing the Government's efforts in monitoring and enforcing the private hospitals' compliance with the land grant conditions, Audit is not in a position to ascertain the reasonableness/propriety of the related party transactions mentioned in paragraph 3.13(a) to (d). Audit is however concerned that the DH had not adequately clarified and enforced the "profit/surplus plough-back" requirement in the land grants. Given that, in the case of Hospital D and Hospital F, significant licence fees/donations had been paid to the grantees and/or related organisations (see para. 3.13(a) and (b)), the DH should, in addition to annually receiving audited

accounts of the hospitals, have further requested the grantees to submit audited statements to satisfy that surplus the grantees and/or related organisations derived from the hospitals' operations on the PTG sites had been properly ploughed back for hospital improvement or extension in compliance with the land grant conditions. In the case of Hospital D (operating largely on PTG sites and partly on self-purchased land — see Appendix C), based on the unaudited financial summary and supplementary information provided by the grantee to the DH in late September 2012, Audit is concerned that a substantial proportion of the income the grantee received from the operation of Hospital D was used in the improvement and extension of the hospital facilities of another hospital in Hong Kong under the grantee's control and operation (Note 14), and in the development of a nursing school, with a small portion used for the relief of poverty and advancement of education outside Hong Kong. As at late October 2012, the DH informed Audit that it was seeking the Lands D's advice on the propriety of the way the grantee had disposed of the income.

3.15 Audit welcomes the DH's initiative of introducing the new requirement of requiring the submission of hospital auditors' certification on compliance with the financial-related land grant conditions (see para. 3.6) and appreciates that the DH made its enquiries in March and August 2012 on the various related party transactions reported in the hospitals' statements of accounts (see para. 3.13(a) and (b)). Nonetheless, Audit considers that more needs to be done to:

(a) define what permissible activities the non-profit-making grantees/hospitals are allowed to conduct and what non-permissible activities disallowed in respect of profits derived from the hospital operations on PTG sites and similarly, what profit-sharing arrangements they can make with related and third parties; and

(b) step up the monitoring of the requirement for grantees/hospitals to retain and reinvest their profits/surplus in the hospital operations, as set out in the land grants.

Note 14: *This is a sister hospital of Hospital D. It is also a non-profit-making hospital and is not operating on PTG sites. The land lease contains no restrictions on the distribution of hospital profits/surplus.*

Site development not strictly in accordance with land grant conditions

Social centre for the elderly and day hospital with rehabilitation facilities required

3.16 As shown in Table 2 in paragraph 2.10, LG 4 to Hospital C did not contain any "free or low-charge beds" requirement. This was because the PTG was granted to Hospital C not for providing in-patient hospital services, but for operating a non-profit-making medical, health and welfare centre which would provide a "social centre for the elderly" and a "day hospital with … rehabilitation facilities", for which the "free or low-charge beds" requirement was not applicable.

3.17 It transpired that, as at September 2012, LG 4 was used by Hospital C as a hospital block providing, among others, 112 hospital beds and including 3-storey wards with first-class and second-class rooms. According to DH and Lands D records, and confirmed by a site visit paid by Audit on its own in mid-August 2012 (Note 15), Audit could not find prima facie any "social centre for the elderly" or any "day hospital with … rehabilitation facilities" in the hospital block as stipulated in the land grant.

3.18 The site was granted in February 1980 to the parent organisation of Hospital C by PTG at nil premium to provide health and welfare services (and not in-patient hospital services). In April 1981, the site was surrendered by the parent organisation and re-granted to Hospital C as LG 4 with revised conditions. Under the 1981 land grant, the grantee was expected to operate a non-profit-making health and welfare centre on the site providing:

(a) a day nursery catering for between 140 and 196 children;

(b) a geriatric day centre with facilities for vocational therapy and occupational therapy for about 80 patients;

Note 15: *A separate visit was paid to Hospital C in September 2012, accompanied by DH staff. Audit did not find any "social centre for the elderly" or "day hospital with … rehabilitation facilities" having been properly set up in the hospital block.*

(c) a non-residential training school for enrolled nurses; and

(d) such domestic quarters as the Social Welfare Department (SWD) and the DH considered to be essential for the housing of staff and workmen employed on the premises.

The health and welfare centre, made up of 7 storeys, came into operation in 1983.

3.19 In June 2002, on the grantee's application and with the policy support of the then Secretary for Health and Welfare and the support of the DH and the SWD, LG 4 was modified to allow for change of the "type of building" condition at nil premium to read as follows:

> "The grantee shall in accordance with these Conditions erect and thereafter maintain upon the lot a non-profit-making medical, health and welfare centre providing a social centre for the elderly and a day hospital with such clinics, rehabilitation facilities and other facilities as may be approved by the Director of Health … and shall not at any time erect or maintain upon the lot any building other than a building or buildings for the purposes of the said centre except with the prior written approval of the said Director" (i.e. the Director of Lands).

3.20 During the drafting of the revised "type of building" condition, Hospital C had clarified with the Government that:

(a) the social centre to operate on the site was a self-financing one which would serve the elderly;

(b) the day hospital was to provide day service for physically disabled or patients who required physiotherapy or occupational therapy; and

(c) the day hospital with rehabilitation facilities and clinics would form part of the ambulatory services of Hospital C.

At that time, the DH also informed the Lands D that the operation of the medical centre was in the form of a day hospital with rehabilitation facilities and clinics. That is, LG 4 was expected to provide, among others, a "social centre for the elderly" (under the SWD's purview) and a "day hospital with … rehabilitation facilities" (under the DH's purview). The DH records indicated that before the redevelopment (see para. 3.21), both of these two facilities were available within the premises on LG 4.

3.21 In 2006, Hospital C proceeded to redevelop the premises on LG 4. In March 2008, the Buildings Department (BD) issued an occupation permit for the hospital block on LG 4 (Note 16). In April 2008, the hospital block commenced operation. However, based on the hospital's correspondence with the FHB and the DH at that time, it appeared that both the "social centre for the elderly" and the "day hospital with … rehabilitation facilities" were no longer available within the hospital block. Without any assessment of the minimum number of hospital beds to be included as a land grant condition, the DH had approved the hospital's application for providing 109 hospital beds under the Ordinance in the hospital block.

3.22 In March 2010, Hospital C made an application to the Planning Department (Plan D) for the addition of one more storey to the hospital block (i.e. 13 storeys in total), at which time the hospital block was providing, inter alia, the following services:

- 5-storey wards, including 3-storey wards with first-class rooms
- Heart centre
- Specialist clinics
- Pathology department and pharmacy department
- Wellness centre

Note 16: *According to the occupation permit then issued, the hospital block was described as "a ten-storey hospital over two-storey basement for non-domestic use".*

No minimum number of hospital beds set and no "Not less than 20% low-charge beds" requirement

3.23 Because LG 4 was not granted to Hospital C for operating in-patient hospital services, the land grant contained neither the minimum number of hospital beds that should have to be provided on the site nor the requirement to provide not less than 20% low-charge beds.

Delay in lease modification for building redevelopment until 2011

3.24 On Hospital C's application for redeveloping the premises on LG 4 (see para. 3.21), including applying for a relaxation of the building height restriction under the lease and for erecting a 2-storey connection bridge between the sites of LG 4 and LG 3, the Lands D issued in November 2004 a provisional basic terms offer for a proposed lease modification to the hospital relating to LG 4. Further, a lease modification of LG 3 was also necessary and the grantee applied for the lease modification in 2005. The two lease modifications in respect of LG 3 and LG 4 were eventually only executed in March 2011, some three years after the new hospital block commenced operation in April 2008 (Note 17).

Changes in the primary use of the land not yet properly approved under the land grant conditions

3.25 ***Hospital building plans not yet approved by Lands D.*** The Lands D is responsible for processing building plans under the lease. LG 4 had contained a "design and disposition" condition which stated that the design and disposition of any building to be erected on the lot shall be subject to the Lands D's approval. Audit however found that, although the BD had approved the redeveloped building plans on LG 4 and the hospital block has been in operation since 2008, up to early September 2012, none of the building plans (with the first plan submitted in

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Note 17: *Although time had to be allowed for finalising the positions of the connection bridge and for agreeing the terms of the lease modifications, the fact that the lease modification to LG 4 was only executed some three years after the hospital block commenced operation appears too long. There was all along no change in the "type of building" condition (see para. 3.19).*

November 2007) had been approved by the Lands D under the land grant conditions (Note 18). In October 2012, the Lands D informed Audit that until the building plans had been found to have met the lease requirements to the satisfaction of the relevant authorities, it would not approve the building plans.

3.26 ***Compliance confirmation by sponsoring departments.*** LG 4 has also stipulated the following "building plans" condition:

> "The grantee shall, before any building operations commence on the lot, submit or cause to be submitted to the Director of Medical and Health Services and the Director of Social Welfare for approval building plans for the said centre and thereafter shall, without prejudice to the generality of any other General and Special Conditions herein contained, construct the centre in accordance with such building plans as approved by the Director of Medical and Health Services and the Director of Social Welfare."

That is, the DH and the SWD, as the sponsoring departments for the PTG, should have raised objections had they found, from an examination of the grantee's building plans and plan amendments, that there was no "social centre for the elderly" and no "day hospital with ... rehabilitation facilities" in the new hospital block on LG 4.

3.27 Although the SWD acknowledged the proposed lease modification which was copied to it in 2004 (see para. 3.24), it was not consulted on the building plans until February 2012. Because the Lands D kept on receiving the hospital's building amendment plans, it reminded the hospital several times from 2009 to 2011 to submit building plans showing the social centre portion and the hospital portion, but only received from the hospital in November 2011 a full set of building plans (relating to the position in November 2007 — see para. 3.25) which showed a social welfare element within the development. In March 2012, the SWD informed the Lands D that the "social centre for the elderly" shown on the building plan under

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Note 18: *The BD approves the building plans and plan amendments under the Buildings Ordinance (Cap. 123), which is independent of the Lands D's approval of the land lease.*

processing by the Lands D "seems to be incorrect" (Note 19). In September 2012, the Lands D was still seeking clarifications from the hospital on the status of the "social centre for the elderly" on LG 4.

3.28 In the case of the DH, it had so far not raised any objections on the grantee's building plans either to the BD and/or to the Lands D. In October 2012, the BD informed Audit that under its centralised plan processing procedures, the building amendment plans submitted by the hospital would always be referred to the Lands D, and comments from the DH and the SWD would only be sought on a need basis (e.g. where there was a major change in the floor usage or layout in any particular plan amendment). Audit noted that on most occasions when the BD approached the DH for comments on the building plans and plan amendments, the DH indicated that it had no comments (Note 20). In August 2012, on enquiries from the Lands D, the DH confirmed to the latter that a medical and health centre was in operation on LG 4, but did not indicate whether a "day hospital with … rehabilitation facilities" was available on the site. As at October 2012, the Lands D had not yet approved the hospital building plans pending further clarifications.

3.29 The audit observations noted in paragraphs 3.23 to 3.28 indicate that there were various inadequacies in the way the Administration has handled and monitored the granting of LG 4 to Hospital C. Given the absence of any minimum number of hospital beds to be provided on LG 4 and various non-compliances with the land grant conditions (e.g. hospital building plans had neither been approved by the Lands D nor confirmed for compliance with the land grant conditions by the DH and the SWD), Audit considers that the Lands D and the DH, in consultation with the SWD, need to require the grantee to rectify the various irregularities found on LG 4 as early as possible.

Note 19: *In October 2012, the SWD confirmed to Audit that based on its records, after the proposed lease modification was copied to it in 2004, it had not been consulted or advised of the further progress until February 2012.*

Note 20: *In September 2012, the DH informed Audit that it would only raise objections if the building design was found unfit for the accommodation of the proposed facilities under the Ordinance.*

Sub-leasing of hospital premises

Sub-leasing in Hospital E

3.30 Hospital E was established on LG 7 with a site area of 1,600 m^2. The land lease lasted for 75 years from July 1898 renewable for 24 years, and was extended in 1993 for another 50 years up to June 2047 (see item (d) in Table 3 in para. 2.12). The site was originally granted for the erection of a preparatory school. In 1934, ExCo approved the erection of a hospital on the site. As a result, the site was primarily occupied by a school and a hospital.

3.31 The land lease contains an alienation restriction which reads as follows:

> "… and will not sell assign mortgage charge demise underlet part with the possession or otherwise dispose of or encumber the said piece or parcel of ground or any part thereof or any building thereon without the consent of the Governor-in-Council first had and obtained."

In 1993, the grantee agreed with a third party charitable organisation (Organisation E) for the latter to take over the administration of Hospital E, which occupied a portion of the site (the hospital part). No rent was charged. The agreement was effective from 1 April 1993. In the same year, the grantee applied for the Government's consent to letting the hospital part of the site to Organisation E. Given that the DH had confirmed no objection to the granting of the waiver, the Lands D considered and decided, after consulting its policy bureau, that submission to ExCo was not warranted. Thus, it approved, at nil fee, a temporary waiver of the alienation restriction in February 1996 and two extensions of the waiver, with the last waiver expired in March 2005, as follows:

Time of issue	Approval of waiver and extensions
(a) February 1996	The Government approved a temporary waiver for a term of 3 years from April 1993 to March 1996.
(b) May 1996	The Government approved an extension of the temporary waiver from April 1996 to March 1999.
(c) November 2003	The Government approved another extension of the temporary waiver from April 1999 to March 2005.

3.32 During the course of examining the waiver renewal application in (b) above, the Lands D found in an inspection in early 1999 that Organisation E had sub-let certain parts of the hospital premises to three medical centres. Another inspection in 2001 further found that two more medical centres were in operation within the hospital premises. According to the legal advice then obtained for the operation of the medical centres, such joint venture would constitute a breach of the restriction on alienation as contained in the lease of the lot. Accordingly, the Lands D urged the grantee in 2001 to rectify the breach. In 2003, upon noting that the service agreements entered into by Organisation E with the medical centres had been revised and considered acceptable by the legal advisor to the Lands D, the Government approved the second extension of the temporary waiver to March 2005 (see para. 3.31(c)).

3.33 In July 2004, the grantee applied for a further renewal of the temporary waiver for a term of 6 years from April 2005 to March 2011. The grantee also informed the Lands D that 7 medical centres (providing Chinese medicine services, rehabilitation services, laboratory and diagnostic services, skin and cosmetic laser surgery, etc) were in operation within the hospital premises. The subletting issue was again brought up for review.

3.34 According to legal advice obtained in October 2009 by the Lands D, six of the seven service agreements then submitted by Organisation E did not constitute sub-leasing, but one might still constitute sub-leasing because the agreement involved the granting of an exclusive use of a specified area of the hospital premises to the medical centre. According to the legal advice obtained by the Lands D, the continued sub-leasing of the hospital premises to Organisation E without a renewal of the waiver, with further sub-leasing of the premises by Organisation E after the expiry of the waiver in March 2005, was a breach of the alienation restriction. However, since November 2009 (after obtaining the legal advice), the Lands D had taken no action on the land lease. Up to July 2012, there had not been further progress on renewal of the temporary waiver with the one that had lapsed in 2005.

Propriety of continued sub-leasing without renewal of waiver

3.35 It would appear that without the granting of any further temporary waiver, the continued operation of Hospital E on LG 7 by Organisation E (which is not the grantee) and the continued subletting by Organisation E of the hospital

premises to medical centres, were not allowed under the land lease. Audit considers that the Lands D needs to rectify the situation on LG 7 as soon as possible, including seeking the approval of ExCo in accordance with the lease condition if required (see para. 3.31).

Suspected sub-leasing by other private hospitals on PTG sites

3.36 According to the legal advice obtained by the Lands D in 2009 (see para. 3.34), the subletting of the hospital premises on direct land grant sites by third parties would constitute a breach of the non-alienation clause of lease conditions, and waivers were required. Audit noted that in July 2001 when considering the subletting in Hospital E and the waiver in paragraph 3.31(c), the DH informed the FHB that, to its understanding, some hospitals had entered into business arrangements with partners (through subletting premises or contracting out services) in the provision of certain types of hospital services, and that the DH had no objection to the subletting of hospital premises. Nonetheless, the FHB indicated in its memorandum of August 2001 to the Lands D that while it had no objection to the subletting of premises in Hospital E, the breach of the land lease should not be permitted to continue and a new waiver or lease modification to regularise the subletting was essential.

3.37 In this review, Audit has noted that apart from Hospital E, some other private hospitals have also provided specialist medical centres within their hospital premises built on PTG sites (see para. 3.13(c) and (d)). It is understood that with advancement in medical technology, hospitals may enter into contractual arrangements with experts in various medical areas with a view to introducing such advanced medical technology, knowledge and skills as part of the medical services of the hospitals for the benefits of their patients.

3.38 There are however three issues of audit concern, as follows:

(a) similar to Hospital E, whether the provision of such medical centres on PTG sites would constitute subletting which is generally disallowed under the existing land grant conditions;

(b) such medical centres on PTG sites might have been operated by related companies which were profit-making and should have maintained separate accounts from the grantees/hospitals' ones (see para. 3.13(c)). As such, these might constitute profit-sharing arrangements by the grantees/hospitals with third parties, which might not be allowed under the land grant conditions and the DH needs to seek clarifications (Note 21); and

(c) whether the hospital management is responsible for the hospital-related services provided by such medical centres, particularly when patients may assume that the centre services are directly provided by and under the management and supervision of the hospitals.

It would appear that the Lands D and the DH need to clarify if similar situations as in Hospital E also exist in other private hospitals that operate on PTG sites, and take appropriate follow up actions on the above three issues.

Note 21: *Taking one hospital as an example, Audit found that most of the sub-licences were entered into by the hospital with related companies, with the hospital receiving licence fees from the related companies and sharing a relatively small portion of the profits derived from such related companies. Investments in these related companies were included as assets in the hospital's accounts with dividends and licence fees receiving from them included as investment income and licence fee income respectively in the hospital's accounts.*

PART 4: SALE OF LAND FOR PRIVATE HOSPITAL DEVELOPMENT

4.1 This PART examines one land sale transaction in the 1980's that is related to the development of a private hospital in one district of Hong Kong (District G).

What has happened

4.2 According to a public tender awarded in 1982 for the sale of a site of 1.922 ha (or 19,220 m^2) in District G, it was expected that a private hospital would be erected for operation on the site (hospital site), providing not less than 200 in-patient beds, but not more than 600 in-patient beds.

4.3 It transpired that:

(a) of the hospital site of 1.922 ha, only 1.04 ha (54%) was used to operate a private hospital (Hospital G — see Figure 1);

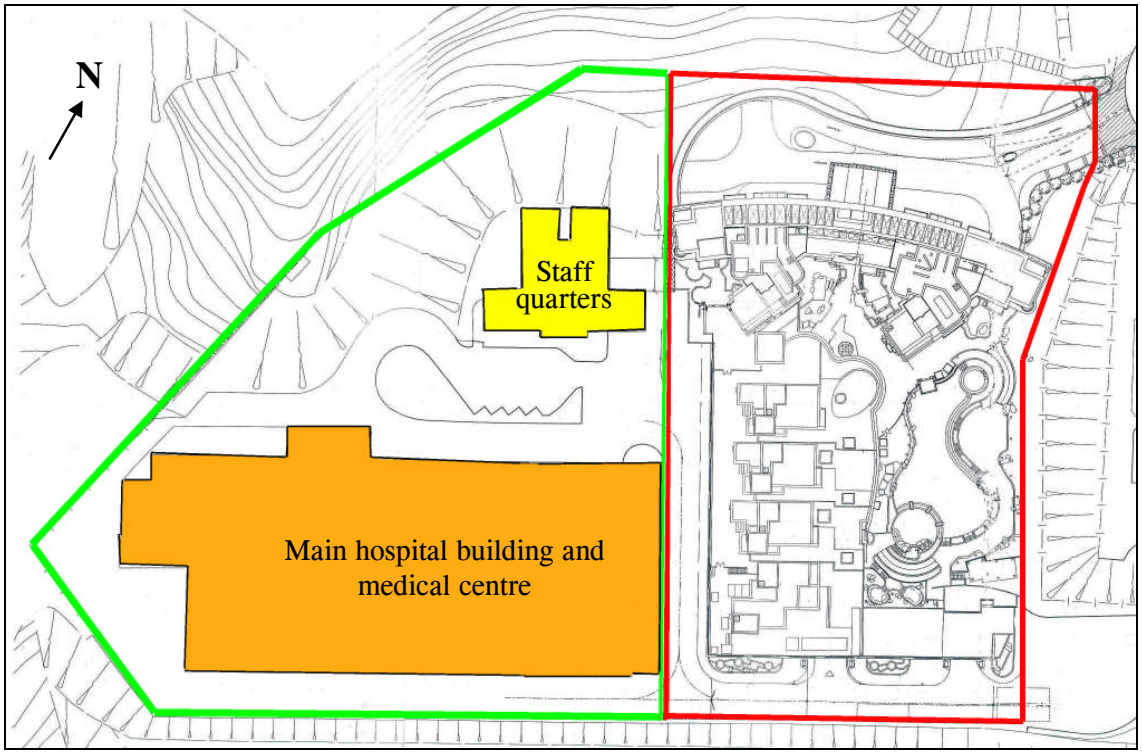
(b) some 0.88 ha (46%) of the site had remained undeveloped for some 20 years before it was approved to be used as private residential development; and

(c) as of today, adjacent to Hospital G on the same site, there is a private residential development (see Figure 1), comprising two high-rise residential building blocks and four house residential units, providing a total of 157 residential units.

In this review, Audit aimed to identify lessons that could be learned by the Government.

Figure 1

Layout plan of hospital site
(October 2012)



Legend: Portion used by Hospital G (54%)

Portion used for private residential development (46%)

Source: BD records

4.4 Hospital G is a profit-making private hospital which commenced operation in 1994 in District G and incurred losses from its operations in the initial years. The hospital was developed in two phases. Phase 1, completed in 1994, provided 212 beds whereas Phase 2, completed in 2006, provided another 200 beds (Note 22). Hospital G currently provides some 410 hospital beds.

Note 22: *Phase 1 of Hospital G included a 7-storey main hospital building, a Medical Centre, a 25-storey staff quarters and an underground car park whereas Phase 2 comprised four additional floors built on top of the Phase 1 hospital building.*

Site area not fully utilised for hospital development

4.5 According to the first tender in 1981, a site area of 1.922 ha was provided for erecting a hospital of "not less than 400 beds, but not more than 600 beds" together with other ancillary facilities and staff quarters. No bids were received. In October 1981, the then M&HD informed the then land authority that:

(a) providing 1.922 ha site for building a hospital of 200 to 400 beds was deemed appropriate; and

(b) it was acceptable to reduce the minimum number of beds from 400 to 200 with a possibility of phased development into 400 beds at some later date.

4.6 In late 1981, in the tender re-issued, the then land authority and the then M&HD reduced the minimum number of beds required to be provided by the hospital from 400 to 200. As there was no revision of the maximum figure of 600 beds for the hospital, the site area remained at 1.922 ha (see para. 4.7). The re-issued tender was awarded to Operator G, a Hong Kong incorporated company limited by shares, in March 1982. Between 1982 and 1989, Operator G underwent three changes of shareholding, with control since 1989 being held by the current major shareholder. Operator G then started constructing Hospital G, with the hospital building plan approved in March 1990.

4.7 Apparently, the Government decision was made to reduce the minimum number of beds from 400 to 200 in order to allow flexibility for the tenderer to develop the site by phases (see para. 4.5(b)). As the maximum number of beds remained unchanged at 600 beds, and given that the site must allow sufficient space to house the maximum development intensity, the Lands D informed Audit in September 2012 that it saw no reason for the then land authority to change the size of the site before re-issuing the tender in late 1981.

4.8 Table 5 shows a chronology of key events and circumstances leading to private residential development on part of the hospital site.

Table 5

Private residential development on part of the hospital site

Month/year	Event
(a) March 1982	The hospital site of 1.922 ha was acquired by Operator G through public tender at a premium of $60.8 million for erecting and maintaining a hospital of not less than 200 beds, but not more than 600 beds.
(b) 1986 to April 2000	• In 1986, Operator G applied to the Lands D for developing the whole site for residential purposes. The application was rejected. • ExCo approved two extensions of the bring-into-operation date to 31 December 1988 at nil premiums. • In 1988, Operator G applied again to the Lands D for partitioning the land lot with a portion for a residential development. The application was rejected. • Operator G underwent three changes of shareholding (two in 1986 and one in 1989), with control since 1989 being held by the current major shareholder. • In March 1990, the BD approved the building plans of Hospital G. • The Lands D further approved extending the bring-into-operation date to March 1994. Owing to the failure to meet the extended deadline of December 1988 for bringing the hospital into operation, Operator G had to pay total premium of $17 million for repeated extensions of time to bring the hospital into operation. • In June 1994, Hospital G commenced Phase 1 operation. • Since 1994 (up to April 2000), Operator G applied repeatedly for changing part of the hospital site to residential use. The applications were rejected.

Table 5 (Cont'd)

(c) May 2000	Operator G lodged a request with the Town Planning Board (TPB) for rezoning the eastern portion of the hospital site from "Government, Institution or Community" ("G/IC") and "Open Space" to residential development. In its request, Operator G also proposed to expand the hospital by constructing additional storeys above the current hospital building to provide additional 200 beds.
(d) June 2000	The TPB agreed to the rezoning request, noting that the undeveloped portion was not required for hospital expansion and the provision of other types of G/IC facilities, the proposed intensity was compatible with the adjacent private residential developments, and that the proposal would not generate significant adverse impacts.
(e) August 2001	Operator G applied to the Lands D for a lease modification to allow the carving out of the "rezoned" portion and for a land exchange for the re-granting of a new residential lot.
(f) September 2001	ExCo approved the proposed Outline Zoning Plan (OZP — Note 23) of District G under section 9(1) of the Town Planning Ordinance (Cap. 131) which included, among others, the rezoning of part of the hospital site to residential use.
(g) October 2001	Notification of approval of OZP was gazetted.
(h) August 2004	Operator G agreed with the Government on the basic terms and premia for lease modification and land exchange, which were $0.31 million and $609.43 million respectively.
(i) November 2004	With lease modification made, a land exchange document was executed.
(j) 2006	Hospital G commenced full operation with Phase 2 development (providing additional 200 beds) completed.
(k) May 2010	Operator G completed the construction of the two residential building blocks and four house residential units. Flats were offered to the open market for sale in October 2010.

Source: Lands D and DH records

Note 23: *OZP shows the land use zones, development parameters and major road systems of an individual planning area. Areas covered by OZPs are in general zoned for uses such as residential, commercial, industrial, green belt, open space, G/IC uses or other specified purposes.*

Private residential development on part of the hospital site

4.9 Land in Hong Kong is scarce and precious. The allocation of a site area for development should only be made after careful consideration of various factors including the nature, scale and contractual obligations of the development project to minimise the risk of over-allocation. Audit examination of the site area provided for developing Hospital G revealed that the site assigned was large enough to cater for a 600-bed hospital plus ancillary facilities. However, the land lease only required the provision of "not less than 200 beds". The purchaser (Operator G) had no contractual obligation to provide more than 200 beds.

4.10 Operator G had complied with the tender procedures and fulfilled its contractual obligations. The fact that it was able to use only 54% of the site area to discharge its contractual obligations and eventually built a hospital with some 400 beds suggests that the provision of 1.922 ha at planning might have been excessive for developing Hospital G. As a comparison, Audit noted that Hospital F, a non-profit-making private hospital, was granted PTG sites (LG 8 and LG 9) of 0.79 ha only for developing a hospital which provided not less than 300 beds.

4.11 According to the hospital layout design, Audit noted that all hospital building and related facilities of Hospital G were provided on one side of the hospital site, taking up only 54% of the total site area. As a result, 46% of the site area was left undeveloped for some 20 years.

4.12 It should be noted that unless there is a breach of lease conditions, or part or whole of the site concerned is required for public purpose, the Government does not have grounds to regain possession of the site or any part thereof once the land is granted or sold. Audit noted that appropriate development controls, such as minimum gross floor area to be provided and height limits were not included in this land lease (Note 24).

Note 24: *There was a height limit only for a small part of the site, but not for most parts of the site. Audit noted that both restrictions on gross floor area and height limits were included in the two recent tenders for private hospital development on the reserved sites (see para. 1.7).*

Due process for change of land use

4.13 Due process has to be followed to enable a change of land use. For similar cases, the hospital site is subject to the following controls to govern changes of land use:

(a) ***Planning control.*** The site was primarily zoned for G/IC use. Rezoning of part of a hospital site to residential use has to go through a statutory process under the Town Planning Ordinance. Any change of planned use (i.e. the G/IC use) under an OZP would involve applying to the TPB for rezoning. ExCo's approval for the proposed OZP was also required; and

(b) ***Lease control.*** If a lessee wants to change the use or restrictions under the land lease to cope with the planned use under the OZP, he further needs to apply to the Lands D for lease modification.

That is, the lessee needs to go through two different steps which involve different considerations. Even after the TPB has approved a rezoning request, there is no guarantee that the Lands D would also approve an application for lease modification to allow a change of land use.

4.14 Therefore, to change the land use, Operator G needed to go through two different steps, i.e. applying to the TPB for rezoning of part of the hospital site and applying to the Lands D for lease modification. During the 14 years since 1986, instead of applying for site rezoning, Operator G applied repeatedly to the Lands D and the TPB for changing part of the hospital site to residential use (see item (b) in Table 5 in para. 4.8). The applications were not approved due to various reasons, including the following:

Time	Event
September 1997	Lands D rejected Operator G's application for lease modification to carve out a portion of hospital site for residential development after taking into account the FHB's comments that it could not support the application on health policy grounds since that site was sold for use as a hospital (Note).
June 1999 and February 2000	The TPB rejected Operator G's planning applications mainly because: (a) the proposed residential development was not in line with the planning intention of the "G/IC" zone and the development could jeopardise the future expansion of the hospital at the subject site; (b) no sufficient justification had been provided to demonstrate that the proposed development would have sufficient planning merits to justify a deviation from the planning intention; and (c) approval of the subject application would set an undesirable precedent for other similar applications in the "G/IC" zone. In February 2000, the TPB also advised that should Operator G consider that the undeveloped portion of the application site was no longer required for hospital use, it should make a request for a rezoning of the hospital site for the residential development proposal.

Note: Although, on this occasion, the FHB did not support Operator G's application on health policy grounds, in May 1998, it informed the then Planning, Environment and Lands Bureau that if the owner could satisfy the obligations laid down in the land grant, it could not see any reasons to object to any proposals which might maximise the potential use of the site.

Rezoning agreed by TPB

4.15 A change occurred in May 2000 when Operator G submitted a rezoning request involving the rezoning of the undeveloped portion of the hospital site from "G/IC" and "Open Space" uses to "Residential" use, in order to facilitate a private residential development. In June 2000, the TPB agreed to the rezoning request, notwithstanding that at that time, the DH had reservations in supporting Operator G's application (see para. 4.16). The TPB agreed to the rezoning request after taking into account other B/Ds' comments, including the following comments of the Plan D:

(a) It had no objection to the proposed amendment to the OZP, and had said that the proposed hospital expansion through the construction of additional 3 storeys over the current hospital block was mainly on the developed portion of the hospital site.

(b) At that time, about 2,580 hospital beds were provided by the hospitals in District G. Based on the Hong Kong Planning Standards and Guidelines (Note 25), there was a shortage of about 890 beds to serve the population in the district. The proposed expansion of the hospital from 212 beds to a total of 400 beds (see item (c) in Table 5 in para. 4.8) would help alleviate the shortfall of hospital beds in the district.

(c) The undeveloped portion of the hospital site was not required for hospital expansion or for the provision of other types of G/IC facilities. Therefore, the undeveloped portion of the hospital site could be released for other uses.

Note 25: *The Hong Kong Planning Standards and Guidelines is a set of guidelines promulgated by the Plan D for application in planning studies, the preparation/revision of town plans and development control.*

4.16 In 1998, the DH held no objection to Operator G's application for residential development on the undeveloped portion of the hospital site. However, in November 1999, April 2000 and June 2000 (before the TPB agreed to the rezoning request), the DH expressed its reservations in supporting Operator G's planning and rezoning applications. Since June 2000, the DH kept on reiterating its reservations and considered that the undeveloped land should be reserved for future development on hospital services. Details of the DH's views on the various applications from Operator G are shown at Appendix D.

Lease modification approved by Lands D

4.17 Following the TPB's agreement to the rezoning request in June 2000, Operator G applied in August 2001 to the Lands D for a lease modification and a land exchange. Before approving the lease modification and land exchange, in February 2002, the Lands D again consulted relevant B/Ds. On this occasion, having noted ExCo's approval of the rezoning (see item (f) of Table 5 in para. 4.8), the DH did not object to the proposed lease modification. Without revisiting the need, in collaboration with the FHB, for retaining the "rezoned" portion of the site for hospital use, the DH informed the Lands D in March 2002 that it had no particular comment on the proposal of carving out the "rezoned" portion for residential development (see item (l) in Appendix D). As relevant B/Ds had been consulted, the Lands D considered that it had followed the due process and had discharged the landlord's role while implementing the planning intention.

4.18 In September 2002, the Lands D approved the lease modification and land exchange, and agreed with Operator G in August 2004 on the basic terms of the lease modification and land exchange, including payment by Operator G of a total land premium of $610 million.

4.19 In October 2012, the Lands D elaborated to Audit that:

(a) although standards on land area for hospital use were contained in the Hong Kong Planning Standards and Guidelines, the expert advice of the DH was most relevant in the decision; and

(b) while planning standards and circumstances might change with time, given that the purchaser had complied with the lease requirements on the development scale, the lot should not be considered under-utilised under the terms of the lease. It should be borne in mind that Operator G had paid for the maximum potential as permitted in the lease in developing the site for hospital purposes.

Issues of audit concern

4.20 Although due process appeared to have been followed in changing the land use, the subsequent change in use of such a sizeable portion of the hospital site for private residential development, albeit after some 20 years had passed, has departed significantly from the original intended use. There are two issues of audit concern on the subsequent development, as follows:

(a) ***A shortfall of hospital beds still existed.*** The hospital site was a precious site. As early as 1986 when Operator G applied for lease modification to permit residential development on the hospital site, the DH had mentioned that in view of the shortfall of hospital beds in the area within which District G was located, the hospital site could not be released without a viable replacement. The Government had then made efforts to find another viable hospital site in the vicinity, but in vain. In 2000, the Plan D confirmed a shortfall of hospital beds in District G (see para. 4.15(b)). In 2004 when the decision was made for using part of the hospital site for private residential development, Audit estimates that there was still a shortfall of some 800 hospital beds in District G (Note 26). As at 2011, the ratio of 4.3 beds per 1,000 population (Note 27) in District G was still below the territory-wide average of 5.1 beds per 1,000 population; and

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Note 26: *With a population in 2004 of 626,700 persons in District G (Source: per Hong Kong Monthly Digest of Statistics), based on a ratio of 5.5 hospital beds per 1,000 population (in accordance with the Hong Kong Planning Standards and Guidelines), some 3,446 beds were required. At that time, only 2,644 beds were available in the district. Therefore, there was still a shortfall of 802 beds.*

Note 27: *In 2011, 2,744 hospital beds were available for a population of 630,300 persons in District G. The ratio was 4.3 beds per 1,000 population. The area's population is projected to grow to 686,000 in 2019.*

(b) ***Possible hospital expansion not ascertained.*** Although Operator G had no contractual obligation to further expand Hospital G, it transpired that in May 2010, Operator G expressed its intention to expand Hospital G and wanted to seek additional land allocation. In September 2010, Operator G further provided the FHB with more details of the proposed expansion plan. However, up to September 2012, there was no further development on any proposed expansion of Hospital G.

Audit considers that the Administration needs to draw lessons from this land sale transaction, which has reflected inadequacies at the planning stage of the land use. Once a site has been allocated for sale for a special purpose (e.g. for hospital services), it will be difficult for the Government to take back possession of the site unless there was a significant breach of lease conditions or a land resumption for public purpose. It would also appear that selling land for building a hospital with a maximum of 600 beds, but setting a contractual requirement of only 200 beds (one-third of 600 beds — see para. 4.9) had left too wide a range to determine the optimum size of the site area. The lack of appropriate development controls in the land lease (see para. 4.12) had also hindered the Government from securing an optimal use of the site for hospital purposes. Therefore, very careful and thoughtful planning, with tight parameters set to regulate the intended use of the land granted, is needed at the beginning.

PART 5: WAY FORWARD AND AUDIT RECOMMENDATIONS

5.1 This PART examines the way forward for monitoring and regulating direct land grants made at nil or nominal premium to private hospitals. In particular, the audit observations and recommendations in this Audit Report could be useful for reference in the implementation of the Government's new policy and strategy approved in January 2011 for the future disposal of Government sites for new private hospitals (see para. 2.7).

Land disposal for new private hospital development

5.2 The Government is at the juncture of reforming the land disposal policy, strategy and arrangements for private hospital development. In the past, when the Hong Kong's economic and social environment was different, Government sites were directly granted at nil or nominal premium to religious or charitable groups to encourage private hospital development. Today, private hospitals generally make profits, some of which are financially very strong. As a result, in January 2011, ExCo approved the adoption of a set of minimum requirements for new private hospitals to be developed on new Government sites. These minimum requirements, covering the following aspects, were included in the tenders issued in April 2012 for the two reserved sites (see para. 1.7):

(a) ***Land use:*** restriction on land use primarily for hospital service while allowing at most 30% of the total gross floor area of the hospital for non-clinical services or facilities, such as accommodation service for families and carers of patients and staff quarters;

(b) ***Date of commencement of operation:*** requirement for the hospital to commence operation within 60 months from the date of execution of the agreement between the successful tenderer and the Government to ensure timely development of the hospital to meet public needs;

(c) ***Bed capacity:*** provision of no less than 300 beds to ensure optimal use of the land;

(d) ***Service scope:*** provision of a mix of specialties without slanting towards any particular types of service. Specifically, the hospitals would be required to provide services of general medicine, general surgery, orthopaedics and traumatology, and gynaecology and to cap the number of obstetric beds at no more than 20% of the total number of beds in the hospital;

(e) ***Packaged charge and price transparency:*** provision of at least 30% of in-patient bed days taken up in a year for services provided at packaged charge through standard beds, and making available comprehensive charging information of services (covering room charges, diagnostic procedures, therapeutic services/procedures, nursing care, medication, consumables and equipment, and other miscellaneous items) for easy reference by the public and patients;

(f) ***Service target:*** provision of at least 50% of in-patient bed days taken up in a year for services to local residents with additional score given for a higher percentage commitment up to 70% to ensure that the priority of the hospital is to meet local demand;

(g) ***Service standard:*** requirement to attain hospital accreditation on a continuous basis to ensure service standard and quality; and

(h) ***Reporting:*** requirement for the hospital to regularly report to the Government on its compliance with the obligations as set out in the tender documents, including those summarised in (a) to (g) above.

5.3 Apart from the above minimum requirements, the Government has adopted the following strategy for the two tender exercises in April 2012 for the reserved sites (see para. 1.7):

(a) ***Two-envelope approach.*** In order to encourage bidders to submit service provision proposals that surpass the minimum requirements and to better serve the needs of the community, the Government has adopted a two-envelope approach in the tender exercises, with greater emphasis on the quality of the service provision than on land premium. In gist, bidders are required to submit their service provision proposals and land premium offers concurrently under two separate envelopes;

(b) ***Higher weighting given to service quality.*** The service provision proposal, which will be evaluated against a pre-defined marking scheme by an assessment panel comprising members from relevant B/Ds, carries a weighting of 70%, while the land premium carries a weighting of 30%;

(c) ***Supplementing land lease by service deed.*** To facilitate monitoring of the operations of the new private hospitals, the successful tenderer will be required to enter into, in addition to the land lease, a service deed with the Government. The service deed, which will be co-terminus with the land lease, will incorporate the successful tenderer's proposals for the operation of the private hospitals; and

(d) ***Enforcement measures for non-compliance.*** A number of measures are available to the Government if the successful tenderer breaches any of its obligations. Such measures include the right to require the successful tenderer to implement a cure plan and pay liquidated damages, the right to exercise step-in rights to temporarily take partial or total control of the hospital and the right to terminate the service deed. The Government may also have resort to the performance guarantee and bank bond provided by the successful bidder.

Future expansion/redevelopment of existing private hospitals

5.4 For existing private hospitals on PTG sites, ExCo approved that the Government would endeavour to replace the special condition for provision of low-priced/low-charge beds included in the land leases of existing non-profit-making hospitals by the minimum requirement for provision of standard beds at packaged charges.

Overall conclusions

5.5 In PART 2, Audit noted that some 1,950 hospital beds, representing 49% of the 4,000 hospital beds provided by all private hospitals, were provided on eight direct land grants made at nil or nominal premium to private hospitals. Although ExCo set as early as 1957 and specified in elaborate terms in 1981 the Two Salient Requirements, namely the need to provide free or low-charge beds and the need to plough back profits/surplus derived from the hospital to improve and expand the hospital facilities, in order to benefit a wider section of the public, Audit found that the Two Salient Requirements had not always been strictly and consistently applied on these direct land grants (see para. 2.12). Given that a PTG would normally last for 50 years or more, and opportunities to include the Two Salient Requirements may only arise when the grantee applies for lease renewal, lot extension or lease modification to cope with any hospital expansion or redevelopment, Audit considers that the Administration needs to fully take such opportunities, and review and revise the land grant conditions as appropriate (see para. 2.13).

5.6 In PART 3, Audit further found inadequacies in the Government's monitoring and enforcement of the relevant land grant conditions, particularly the Two Salient Requirements. Specifically, Audit found that the requirement for the provision of free and low-charge beds imposed on two private hospitals was not effectively enforced (see para. 3.11). With the "profits/surplus plough-back" requirement included in some of the direct land grants to private hospitals, the DH had not timely adjusted its mode and degree of monitoring, and had not effectively monitored the hospitals/grantees' financial affairs to ensure their compliance with the requirement (see paras. 3.13 to 3.15). In particular, Audit is concerned about the related party transactions reported in the hospitals' audited accounts, e.g. licence fees and donations of substantial amounts paid to the grantees and/or the hospitals' parent/related organisations, which had the effect of reducing the hospitals' profits/surplus available for hospital expansion or redevelopment. However, the DH had only stepped up its efforts since December 2010 and March 2012 by requesting private hospitals to submit the hospital auditors' compliance certifications and seeking clarifications with private hospitals regarding their statements of accounts respectively (see para. 3.4(a) and (b)). Not until May 2012 had the DH clarified with the Lands D on suspected non-compliances of the private hospitals with the land grant conditions (see para. 3.8). There was no evidence that the DH had clarified with the FHB and the Lands D on the propriety of the provision of hospital-related services within the hospital premises on PTG sites by profit-making related companies (see paras. 3.13(c) and 3.38(a) and (b)).

5.7 Audit welcomes the Administration's efforts in recent years in reviewing the Government's land disposal policy and appreciates that the Government has developed revised policy, strategy and arrangements for future land disposals for private hospital development (see paras. 5.2 to 5.4). However, noting that the Administration had not in the past effectively defined and enforced the Two Salient Requirements, in the advent of the Government's new approach to encouraging and supporting private hospital development, Audit considers that a proper system is needed to be put in place for the effective application and enforcement of the land grant conditions.

5.8 Land in Hong Kong is scarce and precious. In PART 4, Audit examined one land sale transaction in the 1980's which was related to the development of a profit-making private hospital in District G. Audit however found that at a Government site of 1.922 ha sold in 1982 by public tender for private hospital development, two high-rise residential building blocks and four house residential units were built adjacent to the hospital on the site (see para. 4.3(c)). It transpired that only 54% of the hospital site was used to operate Hospital G, whereas 46% had subsequently been used for private residential development (see para. 4.3(b)), albeit that the change of land use was approved after some 20 years had passed. Audit considers that a requirement to provide 200 beds at the minimum and 600 beds at the maximum was too broad a range to determine the optimum size of the site area. Because the land lease only required the provision of "not less than 200 beds", Operator G had no contractual obligations to provide more than 200 beds. The fact that Operator G was able to operate a hospital with 410 beds on 54% of the hospital site suggests that the site area at planning might have been excessive (see para. 4.10). Audit considers that the Administration needs to draw lessons from this land sale transaction, which has hindered the Government from making an optimal use of the site for the original purpose of hospital development.

5.9 Overall, in order to effectively support and implement the Government's recent reform of the land disposal policy and strategy for private hospital development (see para. 5.2), Audit considers that the Administration needs to critically examine the Government systems and procedures, and improve them, for effectively coordinating, monitoring and regulating direct land grants made in the past decades to non-profit-making private hospitals, as well as for monitoring future land disposals for private hospital development, enforcing conditions in future land leases and service deeds, and providing a level-playing field for all private hospitals.

Audit recommendations

5.10 **Audit has *recommended* that the Director of Health (as the sponsoring department for private hospital development) and the Director of Lands (as the land authority) should take on board the audit observations and recommendations in this Audit Report and improve their systems and procedures for coordinating, monitoring and regulating direct land grants made to non-profit-making private hospitals. More specifically, they should, in consultation with the Secretary for Food and Health and the Secretary for Development as appropriate:**

PART 2: Special land grant conditions set on private hospitals

(a) **take appropriate steps to ensure that future policy decisions made on land grant conditions set on private hospitals are strictly and consistently applied, with approval sought from ExCo as necessary if deviations are required to be made;**

(b) **for direct land grants made in the past to non-profit-making private hospitals, negotiate to impose appropriate conditions (with appropriate service-related issues to be incorporated in service deeds) when opportunities arise, to align with the Government's new approach in promoting packaged charging and price transparency;**

(c) **in the case of LG 8 made to Hospital F, specify the Government's requirements clearly for provision of "low-charge beds and services" in the hospital and clarify the legal position on whether it is feasible for the Government to impose other additional requirements (such as the 2011 minimum requirements) on the operation of the hospital through the use of the "Compliance with prevailing policies" condition available in the land lease (see para. 2.23(a) and (b));**

PART 3: Monitoring and enforcement of land grant conditions

(d) **specify the land grant conditions which the Government expects the hospital auditors to certify for compliance (see para. 3.6);**

(e) **put in place a proper mechanism and step up the Government's controls to monitor the private hospitals' compliance with the land grant conditions, in particular the provision of "free or low-charge beds" and the "profits/surplus plough-back" requirement (see paras. 3.9, 3.11 and 3.13 to 3.15);**

(f) **in the case of Hospital D and Hospital F, request the submission of grantees' confirmations and audited accounts to ensure that they have complied with the "profits/surplus plough-back" requirement in the land grants (see para. 3.13(a) and (b)), and look into other issues highlighted in paragraph 3.13 (such as whether related party transactions and profit-sharing arrangements are permissible under the land grant conditions);**

(g) **require Hospital C to rectify as early as possible, in consultation with the SWD, the various irregularities found on LG 4 (see paras. 3.23 to 3.29);**

(h) **rectify the situation in LG 7 to Hospital E as soon as possible, including seeking the approval of ExCo as necessary for the continued operation by Organisation E (which is not the grantee) of the hospital on the site and its continued subletting of the hospital premises to medical centres, which may or may not be allowed under the land grant (see para. 3.35);**

(i) **take actions to clarify if similar situations as in Hospital E also exist in other private hospitals and take appropriate follow-up on the three issues of audit concern as mentioned in paragraph 3.38, including whether the provision of specialist medical centres (operated by third parties) within the hospital premises on PTG sites would constitute subletting and whether the hospital management is responsible for the hospital-related services provided by such medical centres; and**

PART 5: Way forward and audit recommendations

(j) **periodically assess the effectiveness of the stepped-up enforcement measures taken on existing private hospitals on PTG sites to ensure compliance with land grant conditions, and make any necessary adjustments as required.**

5.11 **Regarding the sale of land for private hospital development in PART 4, Audit has *recommended* that the Director of Lands and the Director of Health should draw lessons, in consultation with the Secretary for Development and the Secretary for Food and Health, from the way the Government had disposed of the hospital site, including the subsequent change in use of a sizeable portion of the hospital site for private residential development. Specifically, the Administration should take actions to prevent recurrence, including:**

(a) **the avoidance of providing a site area which turned out to be excessive for private hospital development (see para. 4.10); and**

(b) **due consideration be given to any existing/potential shortfall in hospital beds and other planning needs when consenting to any change in use of a hospital site for private residential development (see para. 4.20).**

5.12 **On the way forward, Audit has also *recommended* that the Secretary for Food and Health and the Director of Health should**:

(a) **take steps to ensure that the 2011 minimum requirements set for new private hospitals to be developed on new Government sites are properly included in the land leases and service deeds to be entered into by the Government with the successful tenderers (see paras. 5.2 and 5.3); and**

(b) **conduct a post-implementation review, at an opportune time in future, of the Government's new policy and arrangements for private hospital development.**

Response from the Administration

5.13 The Secretary for Food and Health thanks Audit for undertaking this review. He agrees with the audit recommendations. He has also said that:

(a) the FHB will make reference to the audit recommendations in improving the regulation of the compliance of private hospitals with the land grant conditions;

(b) the FHB will take into account the audit observations and recommendations in the Government's review of the Ordinance (Note 28), and will take proactive measures to enhance the regulation of private hospitals; and

(c) as Audit has pointed out, the Administration had imposed a number of conditions in the tender requirements when inviting bids for developing private hospitals on Government sites (see paras. 5.2 and 5.3). The special requirements will be incorporated into the service deed and the land lease of the successful bidder. This will improve a contractual obligation on the hospital operator and if the operator breaches any of the requirements, the Government may take appropriate sanction and action in accordance with the service deed and land lease conditions.

5.14 The Director of Health welcomes and agrees with the audit recommendations, and will take steps to introduce improvement measures. She has said that the DH will continue to work closely with all relevant B/Ds and stakeholders to improve the monitoring of compliance with land grants of private hospitals. She has also said that:

General

(a) the DH will tighten up the monitoring of private hospitals' compliance with land grant conditions pertaining to the provision of healthcare services;

(b) the DH will work with the Lands D closely in the enforcement of land grant conditions on private hospitals;

Regarding the audit observations in paragraphs 2.12 to 2.23 and the audit recommendations in paragraph 5.10(a) to (c):

(c) the feasibility of putting in place a protocol to facilitate coordinated action among B/Ds in drafting, approving and enforcing private treaty grants

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Note 28: *On 11 October 2012, the Government set up a steering committee to conduct a review on the regulatory regime for private healthcare facilities, including a review of the Ordinance.*

should be studied, so as to ensure that ExCo's decisions and relevant policies will be carried out in full. The DH will provide the necessary contributions and supports as required;

(d) the DH will work with the Lands D in ensuring that the relevant land grant conditions have been duly complied with;

(e) the DH will take follow-up actions, as appropriate, regarding the audit recommendation in paragraph 5.10(c);

Regarding the audit observations in paragraph 3.9 and the audit recommendation in paragraph 5.10(e):

(f) a checklist has been drawn up to facilitate the checking of compliance with land grant conditions relating to the provision of private healthcare services. With immediate effect, the monitoring of compliance will be conducted alongside the processing of annual re-registration of private hospitals;

(g) the DH will monitor the private hospitals' compliance with land grant conditions relating to hospital services, provision of free or low-charge beds, and submission of accounts/information on bed utilisation, and will make appropriate referral to the Lands D if any breach is identified;

Regarding the audit observations in paragraphs 3.14 and 3.15, and the audit recommendations in paragraph 5.10(d) and (f):

(h) for hospitals operating on PTG sites with financial-related conditions, the DH has specified the special conditions on which the hospitals should produce auditors' certification of compliance in their submission of annual accounts;

(i) the DH will closely liaise with the Lands D in the monitoring of the compliance with land grant conditions relevant to the provision of healthcare services. In particular, the DH will remind private hospitals to make applications to the Lands D for dubious business arrangements with partners that may contravene the land grant, and make referral to the Lands D for enforcement action if any breach of land grant conditions is identified;

Regarding the audit observations in paragraphs 3.16 to 3.29:

(j) at the time of lease modification (see para. 3.19), there was no intention to limit the user of the day hospital (Note 29) and in order to allow flexibility, Hospital C would be allowed to provide medical services as might be approved by the Director of Health. Moreover, the operation of the medical centre in the form of a day hospital with rehabilitation and clinics would be part and parcel of the hospital's operation, covered by the registration licence of the hospital; and

Regarding the audit observations in paragraphs 4.15 to 4.20:

(k) in February 2000, the TPB rejected the application for change of land use for residential development and in May 2000, Operator G lodged a rezoning request. The DH had reiterated its reservations on the change of land use to the Plan D in writing in April 2000, June 2000, August 2000, December 2000 and March 2001 (see para. 4.16 and items (f) to (k) of Appendix D). It would appear that if guidance notes for considering the applications for change of land use and relevant lease modifications can be provided to the concerned B/Ds, it will facilitate the latter in assessing the applications.

5.15 The Director of Lands generally agrees with the audit recommendations. She has said that:

Note 29: *Based on the Lands D's records in November 2001, Audit noted that when preparing the proposed lease modification, the Lands D stated that the day hospital was for (a) physically disabled; or (b) patients who required physiotherapy/occupational therapy, and there was no intention to limit the user of the day hospital (i.e. the user could be (a) or (b)).*

PART 2: Special land grant conditions set on private hospitals

(a) the Lands D will continue to follow due processes in processing any land grant or land transaction applications for private hospital use including consultation with relevant B/Ds. It will take into account the advice of the FHB and the DH on the land requirements and on any suitable conditions to be incorporated in the land leases, including the need for making references to separate service deeds (see para. 5.3(c)) to be executed between the sponsoring department and the private hospitals;

PART 3: Monitoring and enforcement of land grant conditions

(b) the Lands D will follow up on the outstanding issues under the leases granted and where appropriate take lease enforcement action to support the DH in ensuring compliance with the land lease conditions concerning services-related requirements, such as the submission of accounts requirements, the non-distribution of profits and alienation restrictions if any; and

PART 4: Sale of land for private hospital development

(c) one lesson to be learned from the development of Hospital G might be that the Administration should have been more precise in determining the size of the site required for the delivery of hospital services and in assessing the demand for service expansion.

5.16 The Director of Social Welfare has said that he is prepared to collaborate with the Lands D and the DH to rectify the various irregularities found on LG 4 (see para. 5.10(g)) in respect of the facilities under the SWD's purview.

Appendix A
(paras. 2.5, 2.19
and 3.3 refer)

The 1981 requirements on direct land grants to non-profit-making private hospitals

According to the Lands Administration Office Instructions of the Lands D, the following additional requirements as approved by ExCo in March 1981 should be included in the conditions of grant for direct land grants to non-profit-making private hospitals at nil or nominal premium with effect from March 1981:

(a) The Director of Health shall be informed of the fees charged in the hospital not less than once every six months;

(b) not less than 20% of the total number of beds provided shall be low-charge beds;

(c) the daily maintenance charge for the low-charge beds shall not exceed the maximum charges of the general ward scale in public hospitals: this is to cover beds, food and general services including nursing;

(d) other hospital charges (for the 20% low-charge beds), such as charges for operating theatres, laboratory tests, X-ray tests and drugs shall not exceed 50% of similar charges applied to second-class beds in public hospitals;

(e) by mutual agreement, the Director of Health and the Chief Executive of the Hospital Authority may utilise the low-charge beds provided that the patients using such beds shall not be chronic long term cases and the Government shall pay the fees for such beds which shall not exceed the charges as stipulated in (c) and (d);

(f) any surplus income derived from the hospital shall be directed to the improvement or extension of the medical services provided in the hospital;

(g) duly audited annual statements of account with supporting balance sheets shall be submitted to the Director of Health;

(h) the Director of Health and his officers shall be permitted to inspect the hospital at all reasonable times;

(i) annual statements of bed occupancy of the hospital shall be submitted to the Director of Health; and

(j) any information in connection with or relating to the operation of the hospital as the Director of Health shall in his absolute discretion from time to time require shall be submitted and provided.

Source: *Lands D records*

Remarks: *In Audit's view, conditions in (a) to (f) above provided for the obligations to be fulfilled by the grantees in return for the lands granted to them at nil or nominal premium, whereas conditions in (g) to (j) related to measures of control for the DH to monitor the proper operation of the private hospitals on lands granted.*

Appendix B
(para. 2.9 refers)

Land lots used by Hospital C for hospital purposes

LG/land purchase (LP) no.	Effective time	Land details	Hospital requirements
LG 3 (An area of 5,649 m^2)	March 1982	• PTG at nil premium • 24 years from July 1973 (to expire in 1997)	• Grantee is allowed to erect and maintain upon the lot a non-profit-making hospital together with staff quarters.
	June 1997	• PTG extended to June 2047	
LG 4 (An area of 985 m^2 adjoining to LG 3)	April 1981	• PTG at nil premium • 99 years less 3 days from July 1898 (to expire in 1997)	• ***After 2002 lease modification:*** Grantee is allowed to erect and thereafter maintain upon the lot a non-profit-making medical, health and welfare centre providing social centre for the elderly and a day hospital with such clinics, rehabilitation facilities and other facilities as may be approved by the DH.
	June 1997	• PTG extended to June 2047	
	June 2002	• Lease modification at nil premium	
LP 1 (Land of 740 m^2 adjacent to LG 4)	November 2011	• Lease modification was made to land (purchased by the grantee from the open market) at nil premium for use as hospital	• The purchaser is allowed to erect and maintain upon the lot a non-profit-making hospital of not less than 102 beds. • There should be no distribution of surplus income derived from the said hospital. All surplus income, if any, should be directed to the improvement or extension of the said hospital.

Source: *Lands D and DH records*

Remarks: *Hospital C was in operation on three building blocks on LG 3 and one on LG 4. Another building block was still under construction on LP 1.*

Appendix C
(paras. 2.9, 2.10, 3.12(c) and 3.14 refer)

Land lots used by Hospital D for hospital purposes

LG/LP no.	Effective time	Land details	Hospital requirements
LP 2 (An area of 3,255 m^2)	1936/1940	• Land purchased by the grantee from the open market	***LP 2 and LG 5 (under one lease):*** • LP 2 was unrestricted. ***Conditions applicable to LG 5 only:*** • No building should be erected or maintained on the extension area except a building or buildings required for the purposes of a non-profit-making hospital. *Note: In 1981, ExCo approved, in exchange for the free surrender of a portion of another lot owned by Grantee in relation to a road widening project at a district on Hong Kong Island, the uplifting of various restrictions imposed on LP 2, including the requirement previously imposed on the grantee to direct the hospital's profits to the improvement or extension of the grantee's medical services.*
LG 5 (An extension area of 1,546 m^2 adjoining to LP 2)	February 1959	• PTG at nil premium • 75 years from June 1923 (renewable up to June 2073)	
	June 1983	• Deed of Variation at nil premium (Note)	
LG 6 (An adjoining area of 6,929 m^2)	January 1996	• PTG at a premium of $1,000 • For a term from January1996 to June 2047	• The grantee should erect and maintain upon the lot a building or buildings comprising a non-profit-making hospital of not less than 500 beds together with such other buildings, such staff quarters as considered reasonable for housing staff and workmen employed on the lot.

LG/LP no.	Effective time	Land details	Hospital requirements
LP 3 (An area of 846 m^2 opposite to LG 6)	December 2007	• Purchase of LP 3 by the grantee from the open market	• The lessee should erect on the land: — a non-profit-making training centre for nurses; — a non-profit-making student nurses dormitory; — non-profit-making staff quarters; and — such ancillary facilities as may be approved in writing by the DH.
	February 2012	• Lease modification at nil premium	

Source: *Lands D and DH records*

Remarks: *Hospital D was operating on LG 5 and LG 6, and self-purchased land (LP 2).*

Appendix D
(paras. 4.16, 4.17 and 5.14(k) refer)

Department of Health's comments on Operator G's planning/rezoning/lease modification applications

Time	Event	DH's comments
December 1998	Operator G's planning application to the TPB for residential development on the undeveloped portion of the hospital site	(a) The DH had no objection to the application. (b) In view of the persistent low occupancy of the hospital even in times of good financial environment in the years 1995 to 1997 (occupancy rates varied from 15% to 37%), it was not envisaged that there would be an excess of demand over the planned 400 beds (including the future expansion). Hence, the need of expansion would not be imminent unless there was a drastic change in policy over health financing in which patients would be forced to patronise private hospitals.
November 1999	Operator G's planning application to the TPB for an extension of the hospital, a residential development and an ancillary Chinese medicine research department in the residential development	(c) The DH had reservation in supporting the proposal. (d) Although a gradual increase in the bed occupancy rate of the current 212 beds of Hospital G was noted (up to 62.93% in August 1999), the increase had not significantly indicated the need for the Phase 2 development to provide an additional 200 beds. (e) Consideration on the proposed change of land use was more a matter of land policy decision.
April 2000	Operator G's request for review of the TPB's decision on planning application	(f) The DH suggested the Plan D to consider refuting Operator G's argument that the sale of residential flats would support the development of the hospital, and that the operators should seek other venues to raise funds and not to use the zoned land for such purpose.

Time	Event	DH's comments
		(g) The undeveloped land should be reserved for future development on hospital services in the long run as often seen in other hospital projects.
June 2000	Plan D sought DH's comments on Operator G's rezoning request.	(h) The DH had no particular comment. Its previous comments were still valid.
August 2000	Plan D sought DH's view on objections received to the rezoning request.	(i) The DH indicated that it had already expressed its reservations on the change of land use.
December 2000	Plan D sought DH's view on objections received to the rezoning request.	(j) The comments given in April 2000 (see (f) and (g) above) were still valid.
March 2001	Plan D sought DH's view on submission of written representation by Operator G regarding rezoning request.	(k) The undeveloped land should be reserved for future development on hospital services in the long run as often seen in other hospital projects.
March 2002	Lands D sought the DH's view on lease modification and land exchange	(l) The DH had no particular comment on the proposal of carving out the "rezoned" portion for residential development.

Source: Lands D, DH and Plan D records

Appendix E

Acronyms and abbreviations

Audit	Audit Commission
BD	Buildings Department
B/Ds	Bureaux and departments
DH	Department of Health
ExCo	Executive Council
FHB	Food and Health Bureau
G/IC	Government, Institution or Community
ha	Hectares
IRO	Inland Revenue Ordinance
Lands D	Lands Department
LG	Land grant
LP	Land Purchase
M&HD	Medical and Health Department
OZP	Outline Zoning Plan
Plan D	Planning Department
PTG	Private treaty grant
SWD	Social Welfare Department
TPB	Town Planning Board