For discussion
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LegCo Panel on Health Services
Meeting to be held on 8 April 2002

Financial Situation of the Hospital Authority

Purpose

This paper briefs members on the financial situation of the Hospital Authority (HA) in 2002-03 and the measures HA will implement to address its short-term budget problem.

Financial Situation of HA in 2002-03

2. Government's gross recurrent subvention to HA in 2002-03 is $30,882 million. HA's projected expenditure in 2002-03 amounts to $31,327 million, resulting in a shortfall of $445 million in operating cost. This amount, together with a projected shortfall of $137 million in non-medical income, results in an estimated budget deficit of $582 million in 2002-03, representing about 1.9% of the gross recurrent subvention for that year.

Reasons for the Budget Deficit of HA in 2002-03

3. The main factors contributing to HA's deficit in 2002-03 are set out in paragraphs 4 to 7 below.

Pay Scales and Staff Turnover

4. Under HA's existing salary structure, HA has to incur additional staff cost in 2002-03 to meet the annual salary increment for about 50% of its existing staff who have not yet reached the maximum salary point in their pay scale. The amount is estimated to be in the region of $535 million. At the same time, the current low staff turnover rate makes it difficult for HA to generate savings in

staff cost.

Demand on Services

5. HA has to recruit about 270 doctors, 400 qualified nurses and 135 allied health professions in 2002-03. The intake is necessary to cope with the increase in service demand arising from the ageing and increasing population, as well as to maintain the existing level and quality of service. In line with the international trend, HA has been focusing on the development of ambulatory and community care programmes so as to reduce the reliance on the more expensive inpatient services in the long run. Investment on this front in the short term to address the demand problem entails additional transitional costs.

Advance in Medical Technology

6. Advance in medical technology has resulted in the introduction of new and expensive drugs for the treatment for conditions which hitherto are not amenable to medication, drugs which have been shown to be effective in the treatment of HIV-AIDS, as well as drugs that can enhance the effectiveness of treatment, such as anti-psychotic drugs and cancer drugs. The escalating drug costs have increased the operating cost.

Shortfall in Non-medical Income

7. For 2002-03, HA is expected to generate income amounting to $1,001.8 million, of which $766.1 million is medical income and $235.7 million is non-medical income. The medical income for 2002-03 is budgeted to increase by 2.37% over that of 2001-02, which is equivalent to the projected growth in patient volume for 2002-03 under the population-based funding model. The non-medical income for 2002-03 is budgeted at 0.8% of the approved gross subvention of HA in 2001-02. Due to the continual reduction in interest rates, HA projects that non-medical income will fall short of the budgeted amount by about $137 million.

Measures Taken by HA to Address its Budget Deficit

8. The budget deficit of HA is technical in nature and is expected to be temporary. The additional expenditure on annual salary increment will gradually

taper off when the majority of HA staff reach the maximum salary point in their pay scale. In addition, the measures outlined in paragraphs 9 to 13 below will help address the short-term deficit.

Productivity Enhancement Initiatives

9. Prior to the introduction of the Enhanced Productivity Programme (EPP) by the Government, HA has already achieved 11% saving through HA's own productivity enhancement initiatives. On top of this, HA has achieved another 3% savings in 2000/01 and 2001/02 and is expected to achieve a further 2% savings in 2002/03. HA will continue to implement its EPP initiatives and develop new strategies to generate further productivity savings. These include:

(a) centralization and networking of hospital services among hospitals or clusters to achieve further economies of scale. In this regard, HA is implementing a new cluster-based management through the formation of five mega-clusters;

(b) administrative downsizing of HA Head Office and hospitals, in line with the direction of the implementation of cluster-based management;

(c) re-engineering work processes, such as providing catering services for hospitals/institutions through central production units;

(d) streamlining administrative and management processes, such as setting up financial services centres to provide financial services for a group of hospitals;

(e) centralization of procurement function and system to rationalize facilities, enhance inventory management and logistics, and maximize discounts/savings through bulk purchases; and

(f) implementing "invest-to-save" projects such as energy conservation and automation projects.

The foregoing initiatives will gradually accrue long-term savings in HA, but it will take some time to realize such savings.

Demand Management

10. Through the intake of additional clinical staff to address the demand problem, the provision of health care services in HA can be reengineered to develop the more cost-effective ambulatory and community-based services. Coupled with the integration of General Outpatient Clinics into HA and the change of focus in the delivery of services from service volume to the health outcome of the population, HA can, apart from improving the continuity of care, also provide more cost-effective delivery of health care services and reduce demand on the more expensive inpatient services.

11. HA will continue to strengthen the co-operation and interface with the private sector. To this effect, HA will:

(a) encourage public/private collaboration through the formulation of referr al protocols with private practitioners for the treatment of selected clinical conditions, partnership in discharge planning and shared-care protocols;

(b) develop collaborative models of service provision with the private sector;

(c) develop collaborative skills training programmes to facilitate the upgrading of medical skills of private practitioners; and

(d) facilitate shared-care by sharing patient information with private practitioners.

12. The Government has, in the consultation document on health care reform, set out reform proposals for the system of health care service delivery. These include strengthening preventive care, re-organizing primary medical care, developing a community-focused, patient centred and knowledge based integrated health care service, and improving public/private interface. These proposals would facilitate a more efficient and effective distribution of work between the different levels and sectors of health care provision.

Review of Human Resource Policies

13. As staff cost accounts for 80% of HA's total expenditure, HA will review its Human Resource policies and staff remuneration packages to explore further opportunities for optimizing the use of its resources.

Way Forward

14. HA plans to cover the projected deficit for 2002-03 by its own reserve to ensure that the existing level and quality of public medical services will not be affected. HA will continue to improve its efficiency and cost effectiveness as a health care provider to ensure its long-term sustainability in delivering medical services within the available resources.

Advice Sought

15. Members are requested to note the content of this paper.

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