For discussion
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LegCo Panel on Health Services
Meeting to be held on 19 April 2004

Financial Situation of the Hospital Authority

Purpose

This paper briefs members on the financial situation of the Hospital Authority (HA) in 2004-05 and the measures HA will implement to address its budget problem.

Financial Situation of HA in 2004-05

2. The total amount of Government funding made available to HA in 2004-05 and HA's projected income are as follows -

	2004-05	2003-04
1. Government Funding –		
• Subvention	$27,800.8m	$28,962.5m[1]
• Financial provision under Capital Account (for procurement of furniture and equipment and establishment of information technology systems)	$305.6m	$376.2m
• Funding for extension of jobs created under the Initiatives for Wider Economic Participation (IWEP)	$204.7m	-

2. **HA's income from fees and charges and other non-medical sources**[2]	$1,479.8m	$1,417.6m
Total	**$29,790.9m**	**$30,756.3m**[3]

The HA projects that, on the basis of the Government funding and the estimated income, there would be a budget deficit of $601m for 2004-05. Based on the latest projection, the HA's deficit for 2003-04 is approximately $450m on cash basis.

3. The main factors contributing to HA's deficit are as follows –

(a) under HA's existing salary structure, HA has to incur additional staff cost in 2004-05 to meet the annual salary increment for its existing staff who have not yet reached the maximum salary point in their pay scale according to the contractual agreement with staff. At the same time, the current low staff turnover rate (outside the Voluntary Early Retirement Scheme) makes it difficult for HA to generate savings in staff cost to offset the increase due to salary increment;

(b) one-off ex-gratia payment amounting to $54m to staff who will leave in 2004-05 under the Voluntary Early Retirement Scheme (it should be noted that while the ex-gratia payment is a one-off expenditure for this financial year, there will be savings from this Scheme every year);

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[1] This is inclusive of $160m allocated to HA for the purpose of extending temporary jobs.

[2] The estimation of the non-fee income was worked out based on historical trend. A major part of the non-fee income is the interest from deposit in banks. Because of the prevailing low interest rate, the HA may not be able to generate the estimated amount of non-fee income for these two years.

[3] These figures are exclusive of the additional funding allocated to the HA to meet the unexpected expenditure arising from the SARS outbreak which were separately approved by the Finance Committee.

(c) partial replacement of staff lost through the Voluntary Early Retirement Scheme, the Government's Voluntary Retirement Scheme II and other wastage, and continuation of posts originally planned to be time-limited to meet service demand, operational need and enhance infection control measures;

(d) anticipated increase in insurance and legal expenditure.

The deficit, as the deficit in previous years, will be financed by a transfer from the HA's General Reserve. The accumulated balance of the Reserve stands at $1,391m at 31 March 2003 and will be reduced accordingly.

Measures taken by the Government and HA to address HA's budget deficit

Development of a community-focused, patient-centred health care service that in line with international trend and is financially more sustainable

4. In the Consultation Document on Health Care Reform, we have set out reform proposals for the system of health care service delivery, including the development of more cost-effective ambulatory and community care programmes and to replace, where appropriate, in-patient treatment by ambulatory and out-patient services. Apart from improving the continuity of care, this approach enables HA to provide more cost-effective delivery of health care services and reduce demand on the more expensive inpatient services. This is in line with international development in patient care and is also financially more sustainable. In 2004-05, our target is to increase the percentage of day patients out of the total number of patients treated (inpatients plus day patients) to 28%, as compared with 26% in 2002-03 and 24% in 2003-04. We are also continuing with the Visiting Medical Officer Scheme for residential care homes for the elderly, first introduced during the SARS outbreak in 2003, to improve the quality of care and to reduce hospital admission for elders. For infirmed persons who do not require hospital-based medical care, HA will collaborate with non-Government Organizations and the welfare sector to provide care in non-hospital settings. A pilot project to place a batch of medically stable infirmary patients to be under the care management of a non-Government

organization of the welfare sector is being planned. A similar approach is also adopted for psychiatric service. In line with the international trend, there will be a shift in focus from institutional rehabilitation, which is not necessarily the best treatment and is expensive, to community-based rehabilitation for patients with mental illness.

Development of effective preventive programmes

5. Preventive services are invariably more cost-effective than curative services. Effective preventive programmes will improve the overall health status of the population as well as contribute towards cost saving in the long run. The world trend for healthcare service delivery is for more integrated services across the continuum of care, with greater emphasis on health promotion, illness prevention, and early intervention. In 2004-05, HA will implement and evaluate five patient teaching packages (cardiac, diabetes, renal, respiratory and stroke) in general outpatient clinics and related inpatient areas with the aim to reduce complications and enhance health outcomes. HA will also reduce service demands for conditions with significant burden of disease. In this year, HA will concentrate on two major conditions, namely falls and hypertension. The incidence of fall-related injuries amongst the elderly is far higher than injuries from other causes. Hypertension is a major risk factor contributing to coronary heart disease, stroke, heart failure, peripheral vascular disease and renal failure. HA will conduct falls prevention and hypertension control programmes to improve health of the elderly and reduce service demand. For infectious disease, HA will continue with the "Better Health for a Better Hong Kong" territory-wide campaign targeting at prevention of common infectious diseases through personal hygiene and maintenance of health through healthy living. The influenza vaccination programme will continue in 2004-05 for staff, long-stay patients and elderly with chronic diseases. This will help to prevent influenza outbreak both in institutions and in the community.

Service rationalization

6. HA's takeover of all General Outpatient Clinics from the Department of Health has opened up new opportunities for service rationalization. Hospital clusters will gradually download stable chronic patients from the specialist outpatient clinics to general out-patient clinics,

freeing up the more expensive specialist outpatient services for those in need. The HA will also merge service outlets where appropriate.

Enhance public-private interface

7. One of HA's strategies to ensure sustainability of the public healthcare system is to facilitate free flow of patients between the public and the private sector. HA's initiatives in this respect include making available more private sector information to public patients including service packages offered, price and service information, exploring with the Private Hospital Association and other private service providers the availability of service packages to allow HA patients a greater choice of service and setting up public-private interface Website in HA home page to facilitate information flow between HA and the private sector and enhance the dissemination of private service information to HA's patients. The HA will also explore the feasibility of contracting out certain general outpatient clinics to private providers with appropriate community or Family Medicine training.

Improve the internal resource allocation system

8. In 2003-04, the HA tried out a population-based internal resource allocation methodology. The methodology has proved successful in reducing unhealthy competition among hospitals for activities, promoting initiatives to lessen reliance on hospital beds, and encouraging service rationalization and continuous improvement in technical efficiency. Taking into account the experience gained in 2003-04, the model will be further refined and evaluated.

Introduce private partnership in non-core business

9. The HA will tap private sector resources to reduce the operating costs of its non-core business. A pilot public-private partnership project on food services will be launched to cover two hospital clusters, which accounts for approximately one-third of the total number of meals in all HA hospitals. The result will be evaluated and the initiative will be further rolled out to other hospital if the pilot project is successful.

Enhance planning and procurement for medical equipment

10. In procurement and supplies, much savings have been achieved with the total solution concept implemented in 2003-04. For 2004-05, the HA will put emphasis on further opportunities in bulk contracting of medical equipment. Apart from enhancing its strategic planning process for the management and procurement of major medical equipment, HA will review the bulk procurement arrangement for advanced technology medical equipment.

To continue to explore efficiency saving opportunities

11. The HA Head Office will continue to work with clusters to explore further opportunities for efficiency savings. Realistic corporate-wide and cluster-based plans will be drawn up to achieve productivity / efficiency savings. Given that personal emolument accounts for over 80% of HA's expenditure, central control will continue to be exercised in the human resources area. Replacement, recruitment and promotion of staff will be carefully managed so that staff costs can be contained without compromising the service quality. With the initial success of the last round of the Voluntary Early Retirement Scheme, the HA will consider introducing another Voluntary Early Retirement Scheme targeted at certain services.

To review the existing fee structure to examine whether the subsidy from the public purse can be better targeted

12. The introduction of the charge for Accident and Emergency service and the drug charge and the general revision of charges for public healthcare services was the first steps towards redirecting subsidy from the public purse more appropriately. HA will conduct post-implementation review and analyze other options for the way forward, including the feasibility and pros and cons of proposals such as charging the full cost for the medical expenses incurred by patients covered by mandatory insurance schemes.

To contribute expertise towards long term healthcare financing solution

13. With first hand data on medical expenses of various groups of population, HA will continue to explore options of long term healthcare

financing. In 2004-05, HA will continue to explore options for medical insurance and formulate proposals for further discussion with the Government.

To explore other sources of non-medical income

14. HA will continue to explore other sources of non-medical income.

Way Forward

15. HA will continue to improve its efficiency and cost effectiveness while maintaining quality service as a health care provider. Most of the measures outlined in paragraphs 4 to 13 will take time to achieve results. The HA will pursue these measures not only to ensure the long term sustainability of the public healthcare system, but also to improve patient care in line with international development and to generate the best health outcome for the public funds used.

Health, Welfare and Food Bureau
Hospital Authority
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