The following represents opinions collected from members of Alice Ho Miu Nethersole Hospital Doctors' Association and the frontline doctors of the hospital.

Before we reflect on the "Resource allocation within Hospital Authority Clusters", we would like to point out that resources had been inadequate to meet the demands over the past years. In fact, in a number of clinical departments, the staffing situation (including medical and nursing staff) is even worse than before SARS. Today, the demand and expectation from the public is much, much higher and together with the need to achieve infection control measures and disease surveillance on daily basis has put extra burden on frontline staff.

Resource Allocation from Hospital Authority, as far as we know, has not been adjusted to the change in demand. New Territories Clusters are the ones that really suffer. There is an increase in population in the New Territories in the past few years, and the residents there are from the comparatively lower income class. Demand for public health services are definitely greater than the more affluent population living on Hong Kong side. Besides, there are more private hospitals and 24 hour clinics in the urban areas making less dependent on public health service. The lower rent in New Territories also attracted more establishment of old aged home; and old aged patients are the major users of hospital beds.

In our New Territories East Cluster, due to the relocation of resource, we have seen the closure of a few specialties in our hospital. Emergency consultations for a number of specialties have to be diverted to other hospitals.

The problem facing our frontline doctors in the smaller hospital within the cluster is that we have limited direct support from other specialists in managing patients with multiple problems. For major and emergency conditions the patients will be required to be transferred to another hospital for consultation; for less urgent conditions, the doctor in charge may need to take up initial investigations and treatment that he may not be most comfortable with.

After the clustering, doctors do not station in the same hospital all the time as before. They are deployed according to needs. In a number of clinical departments, the doctors may be deployed to different hospitals within the cluster to take up different responsibilities. Many doctors had expressed dissatisfaction about this as a lot of their precious time that can be used for patient care was wasted in traveling. The frequent doctor movement also makes continued patient care difficult, and makes it

hard to establish a team with close working relationship.

As the major hospitals had all the specialties and provide full medical services, so most junior doctors these days would like to go to the major hospitals for training. Furthermore, most doctors from smaller hospitals had to be rotated to the major hospitals to fulfill their training requirement but not vice versa. Doctors serving in smaller hospitals are at a disadvantage for promotion especially to a major hospital, as they have less clinical exposure, less management experience on cluster level. In this respect, the smaller hospitals are facing difficulties to recruit and retain staff.

Within the cluster, resource allocation had been skewed towards the major hospital because of historical reasons. They are also in positions to get more resources each year because they are the tertiary center, and they are often selected to initiate new service and new treatment plans.

After clustering, the administrative power resided in the cluster management and the management team is usually stationed in the major hospital. As a result, clerical and administrative support are more readily available there than in the smaller hospital.

The largest institution in the cluster is often the resources allocation center and the difficulties of frontline staff in the smaller institutions are often not so well reflected.

We suggest that

(1) To establish guidelines to calculate the manpower requirements for each respective specialty across all clusters, based on A&E attendance, outpatient attendances, admissions and other clinical indicators.

(2) To be more transparent in the resource allocation process and address the inequality issues to provide “fairness” for all staff in the same cluster.

(3) Rotation of administrative staff to different hospitals to make them aware of the varied problems encountered.

(4) Clearly defined the role of each hospital within the cluster and the development of some specialized service even in the smaller hospitals.