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Panel on Health Services

Updated background brief prepared by the Legislative Council Secretariat for the meeting on 15 January 2018

Review of the Hospital Authority

Purpose

This paper provides background information and summarizes the concerns of members of the Panel on Health Services ("the Panel") on the subjects covered under the review of the Hospital Authority ("HA").

Background

2. HA is a statutory body established under the Hospital Authority Ordinance (Cap. 113) in December 1990, responsible for managing the public hospital system in Hong Kong. At present, HA provides public healthcare services for the territory through seven hospital clusters, namely, Hong Kong East Cluster, Hong Kong West Cluster, Kowloon East ("KE") Cluster, Kowloon Central ("KC") Cluster, Kowloon West ("KW") Cluster, New Territories East ("NTE") Cluster and New Territories West ("NTW") Cluster. Each hospital cluster comprises a network of medical facilities[1] to provide a full range of healthcare services to their catchment population. These services include 24-hour accident and emergency ("A&E") care, inpatient services, day services, outpatient services, and rehabilitation and community services. HA relies almost entirely (i.e. over 90%) on annual subvention from the Government to finance the delivery of these services. In 2017-2018, the financial provision to

[1] HA currently manages 42 public hospitals and institutions, 47 specialist outpatient clinics and 73 general outpatient clinics. These facilities are organized into the seven hospital clusters according to their geographical locations. Each cluster has designated catchment districts demarcated based on the location of the hospitals (primarily the acute hospitals).

HA amounted to $55.3 billion, representing an increase of $1.86 billion (or 3.5%) over the 2016-2017 revised estimated. The increase is mainly due to an additional recurrent subvention of $2 billion for HA to implement new initiatives and enhance various types of services to cope with the growth in service demand arising from ageing population in 2017-2018. HA also generates its own income which comprises hospital/clinic fees and charges and other income such as interest income and donation. At present, HA manages its internal resources allocation on the basis of hospital clusters. A summary of budget allocation for the hospital clusters from 2014-2015 to 2016-2017 is in **Appendix I**.

3. In view of the ageing population and the changing public needs for healthcare services, the Government set up the Steering Committee on Review of Hospital Authority ("the HAR Steering Committee"), chaired by the Secretary for Food and Health, in August 2013 to conduct a comprehensive review of the operation of HA to explore viable measures for enhancing the cost-effectiveness and quality of its services. The HAR Steering Committee published its report[2] in July 2015, making a total of 10 major recommendations covering the following five areas concerning HA's operation: (a) management and organization structure; (b) resource management; (c) staff management; (d) cost effectiveness and service management; and (e) overall management and control. The Government has set aside additional time-limited resources totalling $1,170 million[3] for 2015-2016 to 2017-2018, on a one-off basis, on areas where extra resources are called for to facilitate HA in implementing the recommendations. HA has set up a special task force to steer the strategy and monitor implementation of the recommendations of the HAR Steering Committee at the HA Board level. With the endorsement of HA Board, HA released its Action Plan[4] in October 2015 for implementing these recommendations in three years.

Deliberations of the Panel

4. The Panel discussed the subjects covered under the review on HA at a number of meetings between 2008 and 2016, and received views of deputations

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[2] The report of the HAR Steering Committee can be accessed at the website of the Food and Health Bureau (http://www.fhb.gov.hk/download/committees/harsc/report/en_full_report.pdf).

[3] The amount includes $300 million for enhancing the existing services of NTW, NTE and KE Clusters; $570 million for re-employing suitable retirees of those grades and disciplines which are facing a severe staff shortage problem, for a specific tenure period to be considered by HA; and $300 million for enhancing staff training.

[4] The full version of the Action Plan can be accessed at the website of HA (http://www.ha.org.hk/haho/ho/cc/HA_Review_Action_Plan_Final_en.pdf). A summary table of specific actions arising from the Action Plan can also be accessed at HA's website (http://www.ha.org.hk/haho/ho/cc/HA_Review_Action_Plan_summary_table_en.pdf).

at two meetings. At the Panel meetings on 20 July 2015 and 20 June 2016, members were briefed on the findings of the review of HA and the progress of HA in implementing the recommendations of the HAR Steering Committee respectively. Separately, at the Panel meeting on 19 June 2017, members were briefed on the strategic review on healthcare manpower planning and professional development which covered, among others, the healthcare manpower for the public sector. The Panel received views of deputations on the strategic review at the special meeting on 4 July 2017. The deliberations and concerns of members are summarized in the following paragraphs.

Management and organization structure

5. Members were concerned about the unevenness among hospital clusters which partly resulted in the high level of cross-cluster activities particularly in the three Kowloon Clusters. There was a view that the coverage of certain hospital clusters needed to be adjusted. Members noted that while the HAR Steering Committee considered the existing arrangement of having seven hospital clusters appropriate, it had recommended refining the delineation of cluster boundary. In particular, the boundaries of the KW and KC Clusters should be adjusted to bring greater benefits and convenience to the patients. There was a view that consideration should be given to re-delineating part of the catchment districts of the KW Cluster to the NTW Cluster.

6. The Administration explained that there were differences among the hospital clusters in terms of the population size of the catchment districts and their needs for public healthcare services, given the different and changing demographic characteristics and economic status of the population, cross-cluster use of HA services, as well as patient's varying treatment complexity in each hospital cluster. To implement the recommendation, HA would re-delineate Wong Tai Sin and Mong Kok from the KW Cluster to the KC Cluster having regard to the supply and demand for healthcare services, as well as the hospital development or redevelopment plans in the respective cluster. Three hospitals, namely Kwong Wah Hospital, Wong Tai Sin Hospital and Our Lady of Maryknoll Hospital, would be re-delineated from the KW Cluster to the KC Cluster. Administrative arrangements for the re-delineation and budget provision for the concerned hospitals would take effect in December 2016 and April 2017 respectively. Re-organization of care provision in the new KC Cluster and associated changes in the KW Cluster would then be implemented by phases.

7. Members noted that each hospital cluster was currently led by a Cluster Chief Executive ("CCE"), who was also the Hospital Chief Executive ("HCE") of the major hospital in the cluster, to manage the overall budget and operation of the hospitals and services for the cluster. Some members were of the view

that the uneven allocation of resources among hospital clusters was due to the existence of fiefdoms among hospital clusters. On the recommendation made by the HAR Steering Committee that HA should re-examine the overall cluster management structure, focusing on and streamlining the roles of CCE, HCE, Coordinating Committee ("COCs") or Central Committee in order to ensure better division of labour, more effective support in cluster management and better alignment of service provision at cluster level, members noted that some frontline doctors of HA were concerned that staff at the corporate and the cluster levels might have different views over the issues under consideration. There was also a view that a proper balance should be struck between strengthening the overall co-ordination role of HA Head Office on service provision and allowing individual hospitals to have flexibility in developing their services.

8. The Administration explained that the recommendation was aimed at, among others, ensuring consistency and coherence in service provision for the respective specialty at the corporate level. To ease the concern of some HA staff about the impartiality of the chairman of COCs and guard against perceived conflict of interest, it was considered that the chairmanship of COCs should be taken up by staff of HA Head Office in the future, instead of concurrently being the Chief of Services of certain public hospitals.

9. Query was raised over the rationale for creating the position of Deputy Hospital Chief Executive ("DHCE") for hospitals where the HCEs concerned had to manage more than one hospital. HA advised that, on the recommendations of the HAR Steering Committee, HA would group two or more hospitals under the management of one HCE to bring the scope of duties of all HCEs to a comparable level. DHCE appointment was a concurrent appointment where the incumbent needed to assist HCEs in coordinating the clinical services and managing the daily operations of the hospitals in addition to his or her current responsibilities.

Allocation of resources among hospital clusters

10. Members had long expressed grave concern that even having taken into account the factor of cross-cluster service utilization, the amount of resources allocated to certain hospital clusters, such as the KE, NTE and NTW Clusters, were disproportionately lower than other hospital clusters when compared in terms of their size of population. Some members considered that HA's internal resource allocation system would result in under-provision of funding to those hospitals which were less endowed to take up complicated cases. In addition, focusing primarily on resource need and service throughput was not conducive to delivering outcome-focused medical care. Members had repeatedly urged HA to address the uneven allocation of resources among hospital clusters. At

its meeting on 14 January 2008, the Panel passed a motion urging the Government to, among others, demand HA to reform its clustering arrangement so as to address the uneven distribution of resources among clusters and among hospitals within the same hospital cluster; allocate more funding to improve the serious shortage of resources in certain hospital clusters.

11. Members therefore in general expressed support for the introduction of a refined population-based resource allocation model as recommended by the HAR Steering Committee, which would be implemented within three years from the time the report of the HAR Steering Committee was published. There was a view that HA should take into account the median income of the population of the catchment districts and the provision of private healthcare services in individual hospital clusters in developing the model. Members urged the Administration and HA to ensure transparency of both formulation of the refined model, and the future allocation of resources under the model.

12. Question was raised as to whether the refined model would take into account the provision of services by some hospitals, such as Castle Peak Hospital, for patients throughout the territory. Concern was also raised over the adequacy of the time-limited funding of $300 million (from 2015-2016 to 2017-2018) for enhancing the existing services of the NTW, NTE and KE Clusters with a view to enabling them to build up the capacity progressively now to serve the growing population demand in their catchment districts.

13. The Administration advised that the refined model to be developed by HA would take into account, among others, the resources required by individual cluster after taking into account the size and demographics of the population residing within its catchment districts, as well as the provision of designated services. It would first require to carve out from the population-based resources utilization analysis the tertiary and quaternary services provided by designated hospitals and other central clinical or support services not being provided across all clusters. HA had commissioned an external consultancy through tender to help develop and validate the model. It was expected that a prototype would be formulated by the consultant team for further deliberation in HA Board by the third quarter of 2016. A consultant document would be published to engage and collect stakeholders' view by then. Since it took time for HA to develop an appropriate methodology for incorporating relevant factors into the refined population-based model and there was a priority need for topping up funding for the NTW, NTE and KE Clusters, the Government had allocated a time-limited funding of $300 million to enhance the existing services of these three hospital clusters while maintaining the baseline funding to other hospital clusters pending the implementation of the model.

Service management

14. Members in general were of the view that the uneven distribution of resources among hospital clusters had resulted in disparity of quality of services among hospital clusters and hospitals, in particular the longer waiting time for first consultation in the specialist outpatient clinics ("SOPCs") of certain hospital clusters. They noted that HA had implemented various annual plan programmes in recent years and initiated a centrally coordinated cross-cluster referral arrangement for selected SOPC services to increase the capacity to handle SOPC cases and manage waiting time. They, however, expressed concern that many patients were not aware of the availability of patient-initiated cross-cluster new case booking service at SOPCs for the major specialties. Members were advised that apart from stepping up publicity through frontline staff, HA had displayed waiting time information for the specialties concerned in SOPCs to facilitate patients' consideration as to whether to pursue cross-cluster treatment.

15. There was a view that the sustainability of the cross-cluster arrangement hinged on whether resources would be allocated to the hospital clusters on the basis of their number of SOPC patients. Additional resources should be provided to underpin those hospital clusters with increasing service demand under the new arrangement, so as to ensure that those hospital clusters originally with a shorter waiting time, and hence attracting more new case bookings from outside the hospital cluster, would not become disadvantaged.

16. Members went further to suggest that in the longer term, HA should enhance its primary care services; flexibly deploy its medical manpower among hospital clusters to cope with the operational needs of pressurized areas; and review the service demand for and service supply of each specialty and hospital cluster to come up with a comprehensive strategy to ensure that all patients would be provided with timely access to specialist outpatient services required.

17. Some members considered that the long waiting time for services of public hospitals was largely due to the lack of financial incentive for hospitals to shorten the waiting time. They called on the Administration and HA to map out a concrete plan to shorten the waiting time for SOPC and A&E services as recommended by the HAR Steering Committee, and ensure that HA had adequate resources to implement the recommendations. To allay the waiting list of elective surgeries, there was also a suggestion that HA should consider increasing the number of operating theatre sessions by extending its regular operating hours.

18. Members were concerned about the rapid increase of service demand for mental health services and the pressure on public psychiatric SOPCs. HA advised that the enhancement in the multi-disciplinary element in the new service delivery model (i.e. the use of trained psychiatric nurses and allied health professionals under supervision of doctors) to provide active intervention for patients with common mental disorder had enabled the availability of more doctor consultation sessions for new cases with a view to shortening the SOPC waiting time. This apart, HA would explore the possibility of introducing a public-private partnership ("PPP") programme to refer suitable and stable patients to the private sector for continual medical follow-ups, so as to help relieve pressure on public psychiatric SOPCs.

19. Members noted that the Financial Secretary had pledged in the 2015-2016 Budget to allocate to HA a sum of $10 billion as endowment to generate investment return for funding HA's PPP initiatives. While most members agreed that HA should expand and roll out more PPP initiatives to make better use of the capacity in the private healthcare sector to help it coped with increase in service demand and enhance patient access to various services, there were some other views that these initiatives should be no substitute for the public healthcare services which were provided to members of the public at highly subsidized rates. As such, PPP initiatives should only be temporary measures to supplement public healthcare services due to the current healthcare manpower constraint.

Staff management

20. Members were particularly concerned about whether the existing staffing policy and structure of HA was optimal for attracting and retaining its healthcare professionals, in particular doctors. The Administration advised that HA had introduced a series of measures to attract and retain doctors in recent years and there was a drop in the turnover rate of doctors. There were views that the HA Head Office should be equipped with greater authority to flexibly deploy its medical manpower among hospital clusters to cope with the operational needs of pressurized areas. Members noted that a recommendation of the HAR Steering Committee was that HA should exercise greater central coordination in the annual recruitment of Resident Trainees and their placement to different specialties.

21. Some members were concerned that the central selection and appointment arrangement for specialty training of Resident Trainees would stall the recruitment process. The Administration and HA advised that the recommendation of the HAR Steering Committee was to enhance the coordinating role of HA Head office in staff management, so as to ensure greater

consistency, fairness and parity in human resources practices at the cluster and hospital levels. In addition, the central coordination in the annual recruitment exercise of Resident Trainees and their placement to different specialties would alleviate the workload of individual hospital departments in this regard and enable early planning to address manpower shortage in certain specialties where staff turnover rate was high.

22. Referring to the provision of a time-limited funding of $570 million to HA for three years starting from 2015-2016 for re-employing suitable retirees, concerned was raised about the re-employment terms of the retiring medical staff and whether they would be deployed to clusters having significant medical manpower shortfall. Question was also raised as to whether the funding would cover the re-employment of the retiring care-related support staff. According to the Administration and HA, the time-limited funding would be used for re-employment of suitable retirees of those grades and disciplines facing a severe staff shortage problem, including care-related supporting staff. For the retiring medical staff, they would be re-employed for performing clinical duties on a full-time basis, and be offered a salary at the same level as the salary they received before retirement. HA would invite the medical staff concerned to consider serving at hospital clusters with severe staff shortage problem. There were, however, cases that they preferred remaining at the hospital clusters they served before retirement.

23. There was concern about the lack of manpower planning and staff development programme for medical social workers ("MSWs") and other allied health professionals working at HA. The Administration advised that the time-limited funding of $300 million to HA for the years from 2015-2016 to 2017-2018 for enhancing staff training would cover all grades. As regards the grade management for MSWs, members were advised that while MSWs were past employed by individual public hospitals to meet local operational needs, senior posts for the grade of MSWs had been created at cluster level following a recent review with a view to strengthening grade management and staff development.

Strategic review on healthcare manpower planning and professional development

24. Members had long expressed concern about the healthcare manpower constraint at HA. They noted from the report of the Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development[5], which was released in June 2017, that the projection results

[5] The report of the Steering Committee can be accessed at the website of the Food and Health Bureau (http://www.hpdo.gov.hk/doc/e_sr_final_report.pdf).

showed that there was a general shortage of healthcare professionals in a number of disciplines in the short to medium term[6]. The Steering Committee had recommended, among others, that HA should make every effort to retain existing healthcare professionals and attracted retired doctors and other healthcare professional to work in the public sector for an extended period of five years after retirement, and continue to recruit non-locally trained doctors through limited registration to alleviate its manpower shortage.

25. Members casted doubt over the assumption of the manpower projection model, under which the demand at the base year (i.e. 2015) was assumed to be at an equilibrium. They considered that there might be an underestimation of the manpower demand. There was a view that the report had failed to provide a concrete plan to resolve the long existing problem of healthcare manpower shortage in HA and address the various suggestions for improving the public healthcare services, such as formulating the medical and nursing manpower to patient ratio and setting a reasonable length of outpatient medical consultation time. There was a call for the Administration to conduct afresh the healthcare manpower projections.

26. The Administration advised that it would conduct manpower planning and projection for healthcare professionals once every three years in step with the triennial planning cycle of the University Grant Committee ("UGC"). It would embark on the next projection exercise in consultation with the relevant stakeholders in the third quarter of 2017 for the 2019-2020 to 2021-2022 triennium.

27. There were views that HA should be provided adequate funding to re-employ suitable retirees and to improve the working conditions and remuneration package for doctors to reduce the brain drain from the public to private sector. Concerns were also raised as to whether HA would recruit and provide training to all locally trained medical graduates even in economic downturn, and whether the recruitment of non-locally trained doctors through limited registration by HA would affect the promotion of local doctors. Members were assured that HA would recruit all qualified locally trained medical graduates and provide them with relevant specialist training.

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[6] The healthcare professionals involved include doctors, dentists, dental hygienists, general nurses, occupational therapists, physiotherapists, medical laboratory technologists, optometrists and radiographers.

Recent developments

28. According to the Government Minute on the subject "Provision of health services for the elderly" in response to the Report of the Public Accounts Committee ("PAC") No. 65 which was laid before the Legislative Council ("LegCo") in May 2016, HA has completed the comprehensive review of appointment scheduling practices of SOPCs as recommended by the Director of Audit. Good practices to optimize the use of the earliest available slots have been identified and incorporated into the SOPC Operation Manual issued to all SOPCs in January 2016. In addition, with the full implementation of the SOPC Phone Enquiry System which allows patients to give notice to SOPCs of their intention to cancel or reschedule their appointments in all hospital clusters, cancelled appointments could be put to effective use and the released quotas could be fully utilized. PAC has referred the subject to the Panel for follow-up in February 2017.

29. In response to the recommendation of the HAR Steering Committee, HA has re-delineated Wong Tai Sin District and Mong Kok area from the KW Cluster to the KC Cluster since 1 December 2016. For non-clinical support services, cut-over from the KW Cluster to the KC Cluster took place on 1 April 2017. On clinical services, reorganization where needed, have been proceed by phases after 1 April 2017 upon readiness of supporting functions and infrastructure to ensure that inconveniences caused to patients would be minimized. Separately, the HA Board approved on 28 September 2017 the acceptance of the Final Report on the Refined Population-based Model submitted by the external consultant[7] to HA. According to HA, starting with the 2018-2019 planning cycle, the analysis under the Model along with other relevant factors would be considered comprehensively for service and capacity planning in short and long term, which would in turn inform resource allocation to hospital clusters.

30. At the meeting of the Panel on 16 October 2017 to receive briefing from the Secretary for Food and Health on the Chief Executive's 2017 Policy Address, members were advised, among others, the followings in respect of the subjects covered under the review on HA:

(a) the Administration would increase the recurrent funding for HA progressively on a triennium basis, having regard to population growth rates and demographic changes. The new arrangement would enable HA to address in a more effective and sustained manner

[7] HA has commissioned The Jockey Club School of Public Health and Primary Care of the Faculty of Medicine of Chinese University of Hong Kong to help develop the Refined Population-based Model.

the staffing and service demands arising from the growing and ageing population;

(b) to utilize the multi-disciplinary healthcare professional teams more effectively, HA would set up more nurse clinics in order to facilitate patients' early access to treatment and continuity of care, and recruit more pharmacists to improve its clinical pharmacy services for patients and help reduce the workload of doctors; and

(c) since there would be over 2 000 medical graduates[8] becoming doctors with full registration in the coming five years, HA would put in place a structured mechanism to ensure that there would be sufficient training relief, protected time and minimum training hours available for its healthcare professionals.

Relevant papers

31. A list of the relevant papers on the LegCo website is in **Appendix II**.

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[8] For 2018-2022, there would be about 420 medical graduates becoming doctors with full registration annually. From 2023, there would be about 470 medical graduates becoming doctors with full registration annually.

Appendix I

Recurrent budget allocation for each hospital cluster of the Hospital Authority from 2014-2015 to 2016-2017

Hospital cluster	Catchment area	Population *(as at mid-2016)*	Budget allocation ($ billion)		
			2014-2015	2015-2016	2016-2017 *(projection as of 31.12.2016)*
Hong Kong East Cluster	Eastern, Wanchai and Islands (excluding Lantau Island)	764 200	5.01	5.37	5.68
Hong Kong West Cluster	Central and Western, and Southern districts of the Hong Kong Island	521 900	5.17	5.56	5.93
Kowloon Central Cluster	Yau Ma Tei, Tsim Sha Tsui and Kowloon City districts	538 300	6.25	6.65	7.14
Kowloon East Cluster	Kwun Tung and Sai Kung districts	1 122 300	4.94	5.28	5.68
Kowloon West Cluster	Districts of Mong Kok, Wong Tai Sin, Sham Shui Po, Kwai Tsing, Tsuen Wan and Lantau Island	1 955 200	10.65	11.46	12.08
New Territories East Cluster	Sha Tin, Tai Po and North districts	1 315 200	7.44	8.13	8.68
New Territories West Cluster	Tuen Mun and Yuen Long districts	1 136 400	6.08	6.71	7.30

Note

Wong Tai Sin District and Mong Kok area have been re-delineated from the Kowloon West ("KW") Cluster to the Kowloon Central ("KC") Cluster since 1 December 2016. The service units in the concerned communities have therefore been re-delineated from the KW Cluster to the KC Cluster to support the new KC Cluster catchment districts with effect from the same date. As a transitional arrangement, reports on services or manpower statistics and financial information will continue to be based on the previous clustering arrangement (i.e. concerned service units still under the KW Cluster) until 31 March 2017.

Sources: Administration's replies to Members' initial written questions during the examination of estimates of expenditure 2017-2018

Appendix II

Relevant papers on review of the Hospital Authority

Committee	Date of meeting	Paper
Panel on Health Services	14.1.2008 (Item IV)	Agenda Minutes
	9.2.2009 (Item V)	Agenda Minutes CB(2)1478/08-09(01)
	11.4.2011 (Item IV)	Agenda Minutes
	9.5.2011 (Item VI)	Agenda Minutes
	18.3.2013 (Item VII)	Agenda Minutes CB(2)1640/12-13(01)
	17.6.2013 (Item III)	Agenda Minutes
	20.1.2014 (Item IV)	Agenda Minutes CB(2)1424/13-14(01)
	10.2.2014 (Item II)	Agenda Minutes CB(2)2083/13-14(01)
	17.2.2014 (Item IV)	Agenda Minutes CB(2)2015/13-14(01)
	19.5.2014 (Item III)	Agenda Minutes
	20.4.2015 (Item IV)	Agenda Minutes

Committee	Date of meeting	Paper
	20.7.2015 (Item II)	Agenda Minutes
	22.10.2015 *	CB(2)97/15-16(01)
	20.6.2016 (Item II)	Agenda Minutes CB(2)261/16-17(01)
	19.6.2017 (Item IV)	Agenda Minutes
	4.7.2017 (Item I)	Agenda Minutes
	16.10.2017 (Item IV)	Agenda

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