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Dear Dr Hon KK Kwok and Dr Hon Fernando Cheung

"Discharge problems" at public hospitals

Thank you for inviting me to the Panel on Health Services and Panel on Welfare Services meeting on 12 June 2006 to give a frontline view of discharge problems at public hospitals. I suppose I am invited because I was one of the contact persons when a group of more than 200 colleagues jointly signed a letter (attached) to the Dr Hon KK Kwok, the Dr Hon Joseph Lee and the media on the captioned issue. After release of the letter, we have received quite a lot of support from fellow colleagues of other hospitals which also encountered patient discharge problems and some comments from various channels. I would like to take this opportunity to supplement the following points:

1. We acknowledge that discharge planning is a complex issue, and many a time, cross-specialty collaboration is required. This may involve clinical assessment and social assessment to match with the needs, as well as appropriate and timely post-discharge supporting services. At times, cross Department assistance is also required. As stated in our letter, most patients and care-givers are considerate and supportive to us. They are willing to arrange discharge of patients for community care despite various limitations. That we are to work in partnership to support their care in the community. Yet there remains a minority group that refuses discharge because of reasons, in our opinion, which they are reluctant to address rather than cannot be solved. Case One (Mr X) in HAHO / HWFB's last submission was an example. And that is the focus that our colleagues voiced out in the letter. Though a small number in headcount, the cumulative bed-days occupied may be great. Moreover, the administrative handicap of not able to discharge them may erode morale of our frontline colleagues. It is also unfair to those who are considerate and exercise civic responsibilities. Moreover, the scarce public resources are not able to be utilized to support those in real need.

2. How are we to solve the issue? The fundamental issue is on incentives and dis-incentives. Imagine if you only have to pay for $68 x 30 = 2040 per month and the "service" is compatible with or better than that of a residential home which charges considerably higher than the hospital, which one will you choose? At present, we can just rely on civic responsibilities to deal with the situation.

We hope that the future healthcare financing model that the HWFB is to put into consultation later this year would give more consideration to hospital charges for patients in sub-acute / rehabilitative hospitals and a system would be incorporated to remove the "incentive" for delayed discharge;

3. What we propose are:
   a) supporting services and residential services to patients and their care-givers should be reviewed so that it can be provided timely and matched to the needs;
   b) a system should be in place to remove "dis-incentives" to be discharged.

Lastly, we would like to re-iterate hereby that we appreciate the support from the majority of relatives / care-givers who are willing to support their disabled relative (patient) in the community. We pledge that we would continue to give as much support as we could to our patients and their families. What we are now drawing your attention to is a group of patient/relatives who refuse to leave despite numerous assistances have been rendered to them. We hope that the public can see into the facts and policy makers can review the system. As professional staff and public servants, we hope that our skills can serve people who are in genuine need of our services and that the limited public money can be put into the best use."

Thank you for your attention

Dr LUM Chor-ming
(Contact person for the letter on "Discharge Problem in Public Hospitals" submitted to the Dr Hon KK Kwok and Dr Hon KL Lee in April 2005)

Appendix I

Editor-in-chief
Hong Kong Standard

26th April 2005

Dear Sir/Mdm

"Discharge problems" at public hospitals

While there is on-going discussion of raising hospitals fees and charges and the long-term health care financing options for Hong Kong, we, as a group of staff from one of the HA hospitals, would like to reflect on a phenomenon we have been witnessing for some years now in our public hospital system. We hope we can add an "insider" dimension to the on-going discussion.

We are working in Shatin Hospital, a convalescent and rehabilitation hospital run by the Hospital Authority. Under the public hospital system, patients usually stay in an acute hospital until their medical conditions stabilize. If fit, they will be discharged home directly. For those in need, they will be transferred to a hospital like ours to undergo a course of in-patient rehabilitation. This in-patient rehabilitation phase usually lasts for three to four weeks. Afterwards and depending on the needs, they may be arranged for community rehabilitation services. Most of the patients could recover to their usual physical state during in-patient stage. Yet, a proportion of them would be left with certain degree of permanent disability, which cannot be improved upon even with further rehabilitation or prolonged hospital stay. Our management goal for them will then be minimizing their disability as far as possible, and to provide them (and / or care-givers) with a wide range of support so that they could reintegrate back to the community. In case the patients cannot be cared at home, our medical social worker would help the family to arrange residential care homes. Though the subvented ones may take some years to enter, patients may be arranged a placement in a private old aged home under the "Enhanced Bought Place Scheme" by the Social Welfare Department. The Social Welfare Department also provides financial support to those who have genuine financial difficulties. Each year, we are able to serve nearly 4000 patients who go through our hospital this way.

However, during recent years, we observe a worrying trend. We note that increasingly,

more and more patients' relatives are refusing the patient to be discharged and they insist to have the patient stay in hospital despite the fact that the patient is already physically fit for discharge and various support arrangements have been made. There are patients who should have been discharged in 2003 but are still remaining in hospital today.

It may appear surprising to lay people why patients refuse to leave hospital, or that care-givers refuse to take patient back home. Some of the cases are due to mis-understandings by care-givers on the then ability of the patient that we have already trained up. Some are due to a lack of sense of security after discharge. Some are due to genuine financial difficulties. As professional healthcare workers, we listen to our patients and their care-givers. We are empathetic to their situation. We address on their concerns. We arrange appropriate support directly or assist them to solve their problems. Most of the cases can be resolved in another couple of weeks, and patient / care-givers are grateful to us when we see them again at follow up. As healthcare professionals working in public sector, we treasure this partnership relationship. We appreciate the efforts from these care-givers. We enjoy the sense of satisfaction derived from being able to provide maximum possible support and care to patient / care-giver in the community within the limit of a tight healthcare budget.

If all the "discharge problem" cases were due to the above reasons, we would not have written this letter. We see a worrying trend that patients / care-givers request to remain in hospital without a sound reason. After we have resolved their claimed problems, they understand that they have no valid reason to remain in hospitals. At the end, they resort to saying that "letting the patient stay in the hospital serves ***'family's/patient's best interest'*** because of the ***'superb quality'*** we offer". In their opinions, even when patients do not need medical and nursing care, and are beyond further rehabilitation and suitable for community support, it ***"serves their interest best***" to have a team of professional nursing staff and supporting staff doing the personal care chores for the patient. In other words, they are treating a hospital as a residential care home only. By doing so, they are taking their advantages at the expenses of patients who are in need of our services and public money.

We try to appeal to their sense of civic duty. If everyone in Hong Kong behaves in such a way, we would have no capacity to provide service for those who are in real need. If the previous patient we treated behaved as what he / she does, we would not be able to take and provide the appropriate rehabilitative services that the patient has received. Their instinctive reply is almost always the same – ***"I do not care about the***

needs of others. I just strive for our own best interest".

We note that this "abuse of hospital system" has been in a worsening trend. We began to have sporadic cases back in 1997 and we started keeping the relevant statistics. An estimation in 2000/2001 showed that the abuse constituted less than 1% of the total hospital utilization figures. This year, the figure has jumpstarted to 7%. What this means in money terms as far as this hospital is concerned is that nearly $10Mn are wasted on those who do not need hospital services.

And this is not unique to our hospital. One of our clinical colleagues in another rehabilitation hospital and who writes regularly for a column in a local Chinese newspaper has estimated that around 6 % of those staying in his hospital are actually fit for discharge and yet refuse to leave. If we take the figure that each rehabilitation bed in Hong Kong is running at the cost of $0.55 Mn a year as a baseline, this would mean that $226Mn are wasted every year in the public healthcare services because of this "discharge problem". This $226Mn is equivalent to the operating expenditure a medium-sized rehabilitation hospital for one year. To put this figure into another perspective, the public has to realize that recent introduction of charges for the emergency medical services only brought the Hospital Authority $58Mn last year. The waste in our hospital system is nearly four times this figure.

We believe that something could be done in the system to rectify the issue, or at least to remove some of the incentives to overstay inherent in our existing system. This can be illustrated by a case. A patient and his family are receiving Comprehensive Social Security Assistance (CSSA). Under the existing welfare system, while a CSSA recipient remains in a hospital, his hospital fees are exempted. Yet the family is still receiving the whole lump sum of CSSA as if the patient is at home. The patient needs only the service of an old aged home but he has ample incentive to stay on in a hospital. What this means is that the patient is enjoying an old age home services at the expenses of public money and opportunity of other patients who are in need of rehabilitative care. This patient has now been in hospital for more than 2 years. If not for his family's refusal to the discharge, the hospital bed may have served more than 30 patients in the past 2-3 years!

For quite sometime, we have been handling the situation locally at our hospital level. This has tasked everyone in the hospital, from frontline staff to the senior management immensely. There was once a case that took nearly 200 man-hours from the senior management to frontline staff to handle before the case was discharged!

This has deprived us of the valuable time and effort of direct patient care to those truly in need. We are most worried with this worsening trend and that the use of a “fire-fighting” approach to deal with each individual case is not working. We think that it is time that policy makers should review the problem and do something to reverse the trend.

The public hospital system is funded entirely with public money. As gatekeepers, we have a duty to ensure that the tax payers’ money is spent on those who are truly in need of our services. We would like to suggest the following action plans:

(a) the Audit Department to investigate on the degree of wastage of public money because of incoordination between the social welfare and public healthcare sectors, and make suggestions on how to minimize it;
(b) While the Health, Welfare and Food Bureau is in the process of reviewing services priority of HA and on Healthcare Financing issues, systems should be put in the future model to prevent occurrence of this “discharge problem”;
(c) Hospital Authority Head Office should face up to and help frontline staff to resolve the problem. A working timetable with observable targets should be set to facilitate public monitoring;
(d) Our Legco representatives should work together with the HWFB and HAHO in resolving and monitoring the work progress of this “discharge problem” issue.

We would like to re-iterate hereby that we appreciate the support from the majority of relatives / care-givers who are willing support their disabled relative (patient) in the community, albeit all the strains and difficulties. We pledge that we would continue to give as much support as we could to our patients and their families. What we are now drawing your attention to is a group of patient/relatives who because of self-interest, refuse to leave despite the fact that they no longer need hospital care. We hope that the public can see into the facts, policy makers can review the system flaws, and senior managers from HAHO can help resolving the issues. We are writing you this letter not for our own interests. As professional staff and public servants, we hope that our skills can serve people who are in genuine need of our services and that the limited public money can be put to the best use.

A group of staff at the Shatin Hospital (with 218 signatures)
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