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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 20 July 2015

Review on the Hospital Authority

Purpose

This paper gives an account of the past discussions by the Panel on Health Services ("the Panel") on subjects covered under the review on 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 ("HKW") Cluster, Kowloon East ("KE") Cluster, Kowloon Central ("KC") Cluster, Kowloon West 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. The recurrent subvention for HA to meet

[1] HA currently manages 42 public hospitals and institutions, 47 specialist outpatient clinics ("SOPCs") and 73 general outpatient clinics ("GOPCs"). 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).

its day-to-day operational needs in 2015-2016 is $49.9 billion[2]. HA also generates its own income which comprises hospital/clinic fees and charges and other income such as interest income and donation, which amounted to $3.2 billion and $1.2 billion respectively in 2013-2014. At present, HA manages its internal resources allocation on the basis of hospital clusters. A summary of budget allocation for the hospital clusters from 2012-2013 to 2014-2015 is in **Appendix I**.

3. In view of the ageing population and the changing public needs for healthcare services, the Chief Executive announced in his 2013 Policy Address that the Government would set up a steering committee 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 Steering Committee on Review of Hospital Authority ("the Steering Committee"), chaired by the Secretary for Food and Health, was set up in August 2013 to review HA's management and organization structure, resource management, staff management, cost effectiveness and service management, and overall management and control.

Deliberations of the Panel

4. The Panel discussed the subjects covered under the review on HA at a number of meetings between 2008 and 2014, and received views of deputations at two meetings. The deliberations and concerns of members are summarized in the following paragraphs.

Review of the Steering Committee

5. Noting that the original target of the Steering Committee was to complete the review in August 2014, some members considered that the Administration should revert to the Panel on the outcome of the interim review conducted by the Review Committee, in particular its initial thoughts on ensuring a more optimal and fairer allocation of resources by HA to its hospital clusters. There was also a concern over the composition of the Steering Committee as most of those members who were from the medical profession were surgeons and belonged to the HKW Cluster.

6. The Administration advised that it took time for the Steering Committee to conduct a comprehensive review on the operation of HA, which included, among others, resource management of HA which was a complicated matter.

[2] Apart from the allocation to hospital clusters, this funding also covered various corporate-wide centralized services of HA.

It was difficult for the Administration to commit when the Steering Committee would complete its study in this regard. At the Panel meeting on 19 January 2015 to receive a briefing from the Secretary for Food and Health on the 2015 Policy Address in relation to health matters, members were advised, among others, that the Steering Committee had completed the initial discussions on various aspects of the review on HA and would consolidate and conclude the discussions and recommendations. It was expected that the review and report would be completed in the first half of 2015.

Management and organization structure

7. 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. 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. The level and scope of services, facilities and expertise available in different hospital clusters also varied, as the portfolio of hospitals was not originally planned on a cluster basis and not all hospital clusters started at the same level. Hence, there existed some degree of mismatch between the supply and demand for hospital facilities. HA had addressed this mismatch through, among others, building of new hospitals and facilities, and expansion of clinical services and development of new services.

8. In the context of discussing the refurbishment of the Hong Kong Buddhist Hospital in May 2014, members were advised that HA was reviewing and assessing the overall demand for and supply of healthcare services in Kowloon taking into account various factors including the rate of population growth and aging, changes in service models, and new developments in medical technology and medical services, as well as developing a clinical services plan for the KC Cluster to map out the future development directions of its hospitals. The review and the service plan were targeted to be completed in 2014.

9. 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 suggestion of rotating

HCE to concurrently serve as CCE to prevent a CCE from favouring the hospital which he also served as HCE and address the problem that the interests of smaller hospitals were often not adequately taken into account, the Administration advised that where appropriate, HA would rotate the postings of CCEs and HCEs to fill the vacancies arising from natural wastage.

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 KE, NTE and NTW Clusters, were disproportionately lower than other hospital clusters when compared in terms of their size of population. They 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. The Administration subsequently advised that HA had introduced a Pay for Performance system in 2009-2010, under which hospital clusters were given additional funding for service growth in areas of greatest needs; improvement in patient safety and quality; and service enhancement through staff development and technology advancement. A Diagnosis Related Groups ("DRG")-based casemix system[3] on acute inpatient services had been developed to measure hospital performance and guide the hospital clusters' baseline budget adjustment (i.e. reduction in baseline budget for those hospital clusters with higher than expected casemix-adjusted cost, and vice versa), and allocate funding for service growth in targeted acute inpatient service areas based upon the casemix price.

12. There were concerns that the casemix approach 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 remained of the view that HA should adopt a population-based resource allocation model. The Administration subsequently advised that from

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[3] Casemix refers to a way of describing the number and type of patients treated by acute hospitals adjusted for complexity according to clinical diagnosis and procedures performed. The casemix model adopted by HA is built upon the DRG system, which is an internationally-adopted patient classification system classifying acute inpatient episodes into different groups based on the level of complexity of diagnosis or procedures performed, demographic characteristics of patients such as age and gender, complications and co-morbidities involved as well as their discharge status. The different groups of DRG can reflect patient's varying level of resource requirement which also serves as an analogy for providers' throughputs.

2012-2013 onwards, HA would determine the resource allocation to hospital clusters (including manpower, equipment, facilities and other operating needs) based on the resources needed to sustain the baseline operations of respective hospital clusters, including their core primary and secondary services as well as any centralized services under their management; additional resources required to deliver the new services that had been supported during the annual service planning process; and any other resources needed to address specific pressure areas or gaps.

13. Members were concerned that the lack of provision of private hospital services in the NTW Cluster, and the long travelling time involved for travelling from the catchment districts such as Tin Shui Wai to other hospital clusters had resulted in high dependency of the population in the districts on public hospital services within the NTW Cluster. There was a suggestion that HA should allocate more resources to the NTW Cluster as a whole and to the Tuen Mun Hospital in particular. According to the Administration, the NTW Cluster had been given a higher percentage increase in the amount of funding for the period of 2008-2009 to 2012-2013, which amounted to 8% in total. On members' enquiry about the ratio of recurrent funding per patient of individual hospital cluster, HA advised that the result of its recent study on resource utilization by its patient population using the DRG methodology revealed that there was a less than 10% difference among the seven hospital clusters in terms of the average resources allocated to each patient.

Staff management

14. 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 to attract and retain doctors, HA had introduced a series of measures, such as creating additional promotion positions, in recent years. With the implementation of these measures, the turnover rate of doctors in HA had dropped from about 5% in the past few years to about 3% the latest. In addition to absorbing local graduates from the two medical schools, HA had recruited non-local doctors to practise with limited registration as one of the short-term measures to address the manpower problem.

15. 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, such as the NTW Cluster where not many doctors were willing to work there. The Administration advised that while cluster arrangement was necessary for better management of public healthcare services, it expected that at the central level,

HA would flexibly and suitably deploy its manpower and other resources among hospital clusters as appropriate. In the context of discussing the cross-cluster referral arrangement for public specialist outpatient services in April 2015, HA advised that the newly recruited Resident Trainees were now required to work in pressurized specialties in addition to the specialties of their choice.

16. On the suggestion that HA should provide financial incentive to attract doctors to work in hospitals located at remote areas, in particular those belonged to the NTW Cluster, the Administration advised that it was understandable that there was a need for HA to maintain a fair and unified pay package across hospital clusters. In recent years, HA had already adopted a more flexible approach to address the manpower constraint issues through employment of part-time doctors and enhancement of its Special Honorarium Scheme to facilitate operation of extra service sessions to meet operational needs of individual hospitals under special projects. HA was also reviewing the mode of re-employment of locally retired doctors and the retirement age for doctors. There was a view that more funding should be allocated to those hospital clusters having inadequate medical manpower so that they could incentivize more doctors to work extra service sessions and employ more part-time doctors to enhance manpower support.

Managing the waiting time for various services

17. 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 SOPCs of certain hospital clusters. They noted that HA had implemented various annual plan programmes in recent years to increase the capacity to handle SOPC cases and manage waiting time. They, however, considered that before the availability of a fairer mechanism for allocating resources among hospital clusters, arrangement should be made to facilitate patients in those hospital clusters with longer waiting time to seek treatments in those hospital clusters with shorter waiting time.

18. Members were subsequently advised that HA had initiated a centrally coordinated cross-cluster referral arrangement for selected SOPC services, such as the specialties of Ear, Nose and Throat ("ENT") and Ophthalmology, in 2012 on a pilot basis to partly address the disparity across hospital clusters in some SOPC services. To enable more patients to benefit from the cross-cluster referral arrangement according to patients' preferences, HA had by phases uploaded SOPC waiting time information on its website since 30 January 2015, covering the eight major specialties of ENT, Gynaecology, Medicine, Ophthalmology, Orthopaedics & Traumatology, Paediatrics, Psychiatry and

Surgery, in order to facilitate patients to make informed decisions when considering whether they should pursue cross-cluster treatment.

19. 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. 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.

20. For the A&E services, there were strong requests from members for shortening the long waiting time for patients to receive treatment, in particular those whose clinical conditions were triaged as semi-urgent and non-urgent under HA's triage system for A&E services, and minimizing the cross-cluster variance in waiting time. HA should also address the serious problem that many patients had to wait for a long time at the A&E departments before getting admitted into an inpatient ward by, say, establishing more Emergency Medicine Wards. The Administration explained that the continuously high demand and the wastage of medical manpower had resulted in long waiting time for A&E services. HA had launched a pilot scheme in 2013 to recruit additional medical and nursing staff to alleviate the work pressure in the A&E departments. Some members considered that the GOPC services of HA should be enhanced to manage patients with less urgent clinical conditions.

21. 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 public-private partnership ("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.

Recent developments

22. Following the completion of a two-year review, the Steering Committee released its report on 14 July 2015, making a total of 10 major recommendations. HA will prepare an action plan within three months with a view to implementing the recommendations within three years. The Government has set aside additional time-limited resources totalling $1,170 million 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. This 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.

23. The Administration will brief the Panel on 20 July 2015 on the findings of the review on HA.

Relevant papers

24. A list of the relevant papers on the Legislative Council website is in **Appendix II**.

Council Business Division 2
Legislative Council Secretariat
17 July 2015

Appendix I

Budget allocation for each hospital cluster of the Hospital Authority from 2012-2013 to 2014-2015

Hospital cluster	Catchment area	Population* *(as at mid-2014)*	Budget allocation ($ billion)		
			2012-2013	2013-2014	2014-2015 *(projection as of 31.12.2014)*
Hong Kong East Cluster	Eastern, Wanchai and Islands (excluding Lantau Island)	774 500	4.39	4.63	5.01
Hong Kong West Cluster	Central and Western, and Southern districts of the Hong Kong Island	530 100	4.53	4.80	5.21
Kowloon Central Cluster	Yau Ma Tei, Tsim Sha Tsui and Kowloon City districts	536 000	5.47	5.84	6.27
Kowloon East Cluster	Kwun Tung and Sai Kung districts	1 098 000	4.12	4.49	4.95
Kowloon West Cluster	Districts of Wong Tai Sin, Mong Kok, Sham Shui Po, Kwai Tsing, Tsuen Wan and Lantau Island	1 945 200	9.00	9.72	10.67
New Territories East Cluster	Sha Tin, Tai Po and North districts	1 266 400	6.49	6.91	7.46
New Territories West Cluster	Tuen Mun and Yuen Long districts	1 099 400	5.20	5.56	6.08

* The statistical delineation of the geographical populations for Kowloon East Cluster/New Territories East Cluster and Hong Kong East Cluster/Kowloon West Cluster has been revised respectively in view of the new services provided to residents of the nearby districts by Tseung Kwan O Hospital and North Lantau Hospital since their commissioning of services. For easy comparison, figures have also been adjusted accordingly.

Sources: Administration's replies to Members' initial written questions during the examination of estimates of expenditure 2015-2016

Appendix II

Relevant papers on review on 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

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