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Panel on Health Services

Updated background brief prepared by the Legislative Council Secretariat for the meeting on 20 June 2016

Review on 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 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 revised estimates of financial provision to HA to meet its day-to-day operational needs in 2015-2016 is

[1] HA currently manages 41 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).

$51.53 billion.[2] 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 2013-2014 to 2015-2016 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.

4. The Steering Committee published its report on 14 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 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.

Deliberations of the Panel

5. The Panel discussed the subjects covered under the review on HA at a number of meetings between 2008 and 2015, and received views of deputations at two meetings. At the Panel meeting on 20 July 2015, members were briefed on the findings of the review on HA. The deliberations and concerns of members are summarized in the following paragraphs.

Management and organization structure

6. 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

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

hospital clusters needed to be adjusted. Members noted that while the 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.

7. 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 consider how the overall delineation of cluster boundary should be refined having regard to the supply and demand for healthcare services, as well as the hospital development or redevelopment plans in the respective cluster.

8. 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 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.

9. 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.

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. 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.

13. Members therefore in general expressed support for the introduction of a refined population-based resource allocation model as recommended by the Steering Committee. Question was raised as to whether the refined model

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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.

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.

14. The Administration advised that the Steering Committee had recommended HA to adopt a refined population-based resource allocation model by taking into account, among others, the headcount and age profile of the local and territory-wide population, as well as the organization of the provision and development of tertiary and quaternary services and hence the additional resources required by selected hospitals or clusters. 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 would 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 refined population-based model.

Staff management

15. 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.

16. 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 Steering Committee was that HA should exercise greater central coordination in the annual recruitment of Resident Trainees and their placement to different specialties.

17. 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.

18. On the question of whether HA would increase the employment of overseas-trained doctors in order to address the existing medical manpower constraint problem, the Administration advised that the Medical Council of Hong Kong ("the Medical Council") would assess applications from HA for the recruitment of non-local doctors to practise under limited registration to supplement local recruitment drive. The Administration had worked with the Medical Council on ways to facilitate more overseas-trained doctors to practise in Hong Kong, such as increasing the frequency of the Licensing Examination from once to twice a year and introducing more flexibility into the internship arrangement.

19. 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 for the next three years to HA 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.

Service management

20. 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, 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.

21. 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.

22. 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 Steering Committee, and ensure that HA had adequate resources to implement the recommendations relating to enhancement of step-down care as well as primary care and rehabilitation services in non-hospital setting in partnership with the non-governmental organizations and the welfare sector.

23. 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.

Implementation of the recommendations

24. Members noted that the recommendations made by the Steering Committee had given an overall direction to guide HA to reorganize its internal management structure, refine its resource allocation system and improve its human resource management policy. HA would prepare an action plan by October 2015 with a view to implementing the recommendations within three years. Concern was raised as to whether HA could fully implement the recommendations according to the schedule. The Administration advised that HA would formulate specific plan to implement the recommendations and report the progress to the Food and Health Bureau on a regular basis.

Recent developments

25. According to the Administration, HA has set up a special task force to steer the strategy and monitor implementation of the recommendations of the Steering Committee at the HA Board level. With the endorsement of the HA Board, HA released its Action Plan on 22 October 2015 for implementing these recommendations in three years. The action plan was issued to Panel members vide LC Paper No. CB(2)97/15-16(01).

26. The Administration will brief the Panel on 20 June 2016 on the progress of HA in implementing the recommendations of the Steering Committee.

Relevant papers

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

Council Business Division 2
Legislative Council Secretariat
16 June 2016

Appendix I

Budget allocation for each hospital cluster of the Hospital Authority from 2013-2014 to 2015-2016

Hospital cluster	Catchment area	Population *(as at mid-2015)*	Budget allocation ($ billion)		
			2013-2014	2014-2015	2015-2016 *(projection as of 31.12.2015)*
Hong Kong East Cluster	Eastern, Wanchai and Islands (excluding Lantau Island)	767 300	4.63	5.01	5.38
Hong Kong West Cluster	Central and Western, and Southern districts of the Hong Kong Island	525 400	4.80	5.17	5.56
Kowloon Central Cluster	Yau Ma Tei, Tsim Sha Tsui and Kowloon City districts	540 300	5.84	6.25	6.66
Kowloon East Cluster	Kwun Tung and Sai Kung districts	1 105 100	4.49	4.94	5.32
Kowloon West Cluster	Districts of Wong Tai Sin, Mong Kok, Sham Shui Po, Kwai Tsing, Tsuen Wan and Lantau Island	1 952 800	9.72	10.65	11.47
New Territories East Cluster	Sha Tin, Tai Po and North districts	1 290 300	6.91	7.44	8.13
New Territories West Cluster	Tuen Mun and Yuen Long districts	1 116 700	5.56	6.08	6.72

Sources: Administration's replies to Members' initial written questions during the examination of estimates of expenditure 2016-2017

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

Committee	Date of meeting	Paper
	20.7.2015 (Item II)	Agenda Minutes
	22.10.2015 *	CB(2)97/15-16(01)

* Issue date

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