立法會
Legislative Council

LC Paper No. CB(2)965/18-19(02)

Ref : CB2/PL/HS

Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the special meeting on 19 March 2019

Operation and manpower 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 issues relating to the operation and manpower 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 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. Being the safety net for all, HA focuses its services on four target areas, namely (a) acute and emergency care; (b) lower-income and under-privileged groups; (c) illnesses

[1] HA currently manages 43 public hospitals and institutions, 49 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).

that entailed high cost, advanced technology and multi-disciplinary professional team work; and (d) training of healthcare professionals.

3. HA relies almost entirely (i.e. over 90%) on annual subvention from the Government to finance the delivery of its services. Starting with the 2018-2019 planning cycle, a new arrangement has been introduced to increase the recurrent funding for HA progressively on a triennium basis, having regard to population growth rates and demographic changes. The overall recurrent subvention to HA in 2018-2019 amounted to $61.5 billion, representing an increase of 10.7% over the preceding financial year. The recurrent subvention will be further increased to $68.8 billion in 2019-2020. 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.

4. Manpower shortage and bed capacity of HA have all along been issues of public concern. According to the Administration, the overall manpower shortfall of doctors and nurses in HA is around 300 and 400 respectively. In 2017-2018, the top 10 specialties in public hospitals with the highest attrition rates of full-time doctors were Ophthalmology (10.6%), Radiology (10.1%), Obstetrics and Gynaecology (9.2%), Psychiatry (7.3%), Anaesthesia (7.0%), Family Medicine (6.8%), Clinical Oncology (6.0%), Pathology (6.0%), Orthopaedics and Traumatology (5.5%) and Medicine (5.0%). The total number of hospital beds of HA was around 28 000 as at 31 March 2018. A breakdown of the number of doctors, nurses, allied health professionals and general beds[2] in HA by hospital cluster in 2017-2018, together with their respective ratios per 1 000 geographical population of the catchment districts, are set out in **Appendix I**. According to HA, as at 30 September 2018, there was a 2.8% growth in the manpower of HA as compared to last year, with the greatest increase (4.3%) in nursing staff. The attrition rate of full-time staff of HA was 9.4% during the period of October 2017 to September 2018, with the care-related supporting staff group recorded the highest attrition rate (14.5%).

5. 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") 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. In response to the recommendations made by the HAR Steering Committee in its

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[2] General beds refer to acute and convalescent beds (excluding infirmity, mentally ill and mentally handicapped beds).

report[3] published in July 2015, HA formulated and released an Action Plan[4] in October 2015 for implementing the 10 major recommendations on five priority areas of (a) management and organization structure; (b) resource management; (c) staff management; (d) cost effectiveness and service management; and (e) overall management and control in three years' time (i.e. by late 2018). HA published the Final Report on Implementation of the Hospital Authority Review Action Plan[5] in October 2018.

Deliberations of the Panel

6. The Panel discussed issues relating to the operation and manpower of HA at a number of meetings between 2008 and 2018. The deliberations and concerns of members are summarized in the following paragraphs.

Resource allocation among and management of hospital clusters

7. Members were concerned about the unevenness among hospital clusters which partly resulted in high level of cross-cluster activities in some clusters. They noted that following the recommendation of the HAR Steering Committee, HA had re-delineated Wong Tai Sin and Mong Kok (involving Kwong Wah Hospital, Wong Tai Sin Hospital and Our Lady of Maryknoll Hospital) from the KW Cluster to the KC Cluster in December 2016. There was a view that the coverage of certain hospital clusters needed to be further adjusted to bring greater convenience to patients. For instance, part of the catchment districts of the KW Cluster should be re-delineated to the NTW Cluster.

8. Members had repeatedly urged HA to address the uneven allocation of resources among hospital clusters, in partpicular the under provision of resources to the KE, NTE and NTW Clusters. Members therefore in general welcome the introduction of a refined population-based resource allocation model as recommended by the HAR Steering Committee, and the commitment announced by the Chief Executive in her 2017 Policy Address to increase the recurrent funding for HA progressively on a triennium basis having regard to population growth rates and demographic changes. 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 the allocation of resources among hospital clusters.

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[3] 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).

[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) (English version only).

[5] The Final Report can be accessed at the website of HA (https://www.ha.org.hk/haho/ho/cc/HA_review_final_sc.pdf) (English version only).

9. The Administration advised that the refined population-based model had taken into account various factors that impacted healthcare utilization (e.g. population size, demographics, socioeconomic factors and chronic diseases burden), as well as the impact of the specialized services that were only available in designated hospitals to serve the entire population of the territory and cross-cluster flow of patients on individual clusters' resources. Starting from the annual planning cycle for 2018-2019, the analysis under the model would serve as one of the considerations to better inform HA's internal resource allocation.

10. 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.

11. 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.

Service management

12. Members noted that the planning standard as set out in the Hong Kong Planning Standards and Guidelines was 5.5 beds per 1 000 population. To cater for the growing healthcare demand arising from ageing population and to improve existing services, the Administration had earmarked $200 billion for the implementation of various hospital projects under the first 10-year Hospital

Development Plan ("the first Development Plan") in 10 years starting from 2016. Members were concerned that the total general bed capacity of HA would only be increased to 26 300 beds by 2026 under the first Development Plan, representing a general bed capacity of 3.4 beds per 1 000 population.[6] There were also concerns that about half of the additional hospital beds (i.e. 2 400 out of the 5 000-odd additional beds) would be provided at the new acute hospital in the Kai Tak Development Area. However, no additional hospital beds would be provided in the NTW Cluster under the first Development Plan.

13. The Administration advised that in the light of an increasing demand for healthcare services, it had already invited HA to start planning the second 10-year Hospital Development Plan instead of waiting for the mid-term review of the first Development Plan to be conducted in 2021. HA would take into account the projected service demands, the physical conditions of existing hospitals, and the planned service models, etc. in the formulation of the second 10-year Hospital Development Plan. Subject to further deliberation, it was expected to deliver 3 000 to 4 000 additional hospital beds as well as other healthcare facilities.

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. While HA had initiated a centrally coordinated cross-cluster referral arrangement for selected SOPC services and refined the service models to shorten the waiting time, some members still expressed concern that the waiting time of certain specialties, such as Orthopaedics & Traumatology ("O&T"), was still long. They considered that HA should step up its effort in increasing patients' awareness of the availability of patient-initiated cross-cluster new case booking service at SOPCs for the major specialties. Additional resources should also be provided to underpin those hospital clusters which

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[6] The estimation was made on the basis that the projected population in 2026 would be 7 825 200 according to the Census and Statistics Department. The bed capacity of 26 300 included prevailing number of hospital beds as at 31 March 2015 and beds that were yet to be opened, additional beds that could be accommodated in existing hospitals through planned ward renovation, additional beds to be provided through the redevelopment and expansion projects under the first Development Plan, and additional beds to be provided through hospital development projects which had already been approved with funding commitment and were currently underway or expected to be completed by 2026. The beds in Hong Kong Children's Hospital were not included. The estimation was also made on the assumption that the Queen Elizabeth Hospital, which currently provided over 2 000 hospital beds, would be fully decanted to the new acute hospital in Kai Tak Development Area. The number of beds to be provided in the redevelopment of King's Park Site was excluded because it would be planned at a later stage.

attracted more new case bookings from outside the hospital cluster. There was a view that HA should set performance pledge such that the Government would allocate adequate resources to improve the waiting time of SOPCs. Members went further to suggest that in the longer term, HA should 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.

15. 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. To enable timely access to SOPC and A&E services and minimize cross-cluster variance in waiting time, the Administration should provide adequate resources to HA to carry out the recommendations put forth by the HAR Steering Committee, such as refining the service model for the high pressure areas of O&T by diverting suitable routine cases to Family Medicine Specialist Clinics, enhancing multidisciplinary teams to cope with the increasing mental health services and increasing consultation rooms to improve the capacity of SOPC services. 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.

16. Members noted that HA was allocated 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.

Manpower planning and staff management

17. Some members pointed out that the existing doctor to population ratio of Hong Kong was not comparable to that of other places. To address the issues of serious wastage and low morale of medical manpower in HA, members held the view that HA should conduct manpower planning and set out a fixed doctor-bed ratio or doctor-outpatient attendee ratio in each clinical speciality. The Administration advised that Hong Kong was a densely populated territory with convenient transportation network, but the population of many other places scattered across wide geographical areas. As there was no universal standard on such ratio, HA considered it undesirable to set a rigid establishment

regarding the number of doctor positions in each clinical speciality in order to maintain flexible adjustment in its establishment for operational needs. It should be noted that starting from 2019-2020, 420 medical graduates completing internship training would be available for recruitment by HA annually. The number of graduating interns would be further increased to 470 from 2023 and 530 in 2026. HA would recruit all qualified local medical graduates to build up HA's medical workforce.

18. Pointing out that HA's nursing manpower had been under pressure for many years, members were of the view that the root of the problem was the lack of a nurse-to-patient ratio. They urged HA to formulate a nurse-to-patient ratio, say adopting the common international standard of one nurse to six patients, for projecting manpower requirement for nurses in the public sector. The Administration advised that there was no universally applicable set of international standard on nurse to patient ratios. Given that healthcare systems of different countries varied, adjustments for differences in care setting were important for such models to be relevant. HA would recruit 2 230 nurses in 2018-2019 to alleviate manpower shortage. It was estimated that there would be a net increase of 830 nursing staff when compared to 2017-2018.

19. Members considered that the manpower shortage problem of HA had adversely affected the quality of care, waiting time of many public healthcare services and the provision of full-fledged services at the newly established hospitals. They were concerned about whether the existing staffing policy, remuneration and working conditions of HA were optimal for attracting and retaining its healthcare professionals. There was also a need for HA to improve the remuneration packages and address the problem of high working pressure of its care-related staff. Some members considered that the policies of promoting PPP and facilitating the development of private hospitals had resulted in brain drain of experienced healthcare professionals from the public to private sectors. Some other members considered that HA should engage more non-locally trained doctors under limited registration to serve in public hospitals.

20. According to the Administration, efforts had been and would continuously be made by HA to attract and retain its staff. Measures already in place included enhancing training opportunities by offering corporate scholarships for overseas training, strengthening manpower support, improving the entry pay and career prospects for care-related staff, and re-engineering work processes. Separately, HA would continue to recruit non-locally trained doctors through limited registration to alleviate the imminent manpower shortage in the public healthcare system.

21. There were views that the HA Head Office should be equipped with greater authority to flexibly deploy its existing medical manpower among hospital

clusters and to co-ordinate the placement of Resident Trainees to different specialties in order to address the operational needs of pressurized areas. The Administration and HA advised that following the recommendation of the HAR Steering Committee, the coordinating role of the HA Head office in staff management had been enhanced to ensure greater consistency, fairness and parity in human resources practices at the cluster and hospital levels. There would be central co-ordination in the annual recruitment exercise of Resident Trainees and their placement to different specialties to alleviate the workload of individual hospital departments in this regard and enable early planning to address manpower shortage in certain specialties where the staff turnover rate was high.

22. Considering that the pay scale of senior executive of HA was on the high side, some members were concerned about the mechanism put in place by HA to consider and determine the remuneration packages of and annual pay adjustment for its senior executives. HA advised that HA offered appropriate remuneration to attract and maintain a stable workforce to render effective hospital services to the public. The remuneration package offered to HA employees on the establishment of HA in 1991 was based on the principle of cost comparability with the civil service. Same as frontline staff, senior executives of HA were remunerated on HA's pay scale which was normally reviewed and revised when the Government adjusted the civil service pay.

23. There was a suggestion that senior executive positions of HA could be filled by administrative personnel specializing in healthcare and hospital management rather than doctors, so that the later could devote their efforts to provide healthcare services at the frontline. HA advised that its recruitment policy was to appoint the most suitable candidates to fill the vacancies of senior executives through open and fair competition.

Recent developments

24. The heavy workload that doctors, nurses and care-related supporting staff of HA are facing amid the manpower shortfall has become an issue of wide pubic concern since Hong Kong entered the current winter influenza season in early January 2019. According to HA, it has enhanced the flexibility of application of special honorarium scheme to a minimum of one hour duty since December 2018, and introduced a one-off 12-week arrangement to increase the rate of the scheme's allowance by 10% from 28 January 2019 to boost the morale of its staff. In addition, HA has recruited tens of doctors and nurses respectively through the newly established Locum Office to serve at public hospitals on a part-time basis. As a measure to retain serving supporting staff

and recruit new supporting staff to help relieve frontline workload, HA proposed on 11 March 2019 an 8% pay rise across all Patient Care Assistants, Operation Assistants and Executive Assistants covering both new recruits and serving staff with effect from 1 April 2019. On 14 March 2019, HA issued a press release on the measures to be rolled out in 2019-2020 to retain and relieve the workload of its nursing staff after its meeting with the Association of Hong Kong Nursing Staff (see **Appendix II**).

25. The Financial Secretary announced in the 2019-2020 Budget Speech that a $10 billion public healthcare stabilization fund would be set up so as to prepare for any additional expenditure which might be incurred by HA in case of unexpected circumstance. An additional $5 billion would be earmarked for HA to expedite its work to upgrade and acquire medical equipment. Separately, an additional recurrent funding of $720 million would be provided to HA to introduce a series of measures for staff retention. The press release issued by HA on the measures to be introduced in this regard is in **Appendix III**.

Relevant papers

26. A list of the relevant papers on the Legislative Council website is in **Appendix IV**.

Council Business Division 2
Legislative Council Secretariat
18 March 2019

Appendix I

Number of doctors, nurses, allied health staff and general beds in the Hospital Authority by clusters in 2017-2018 (as at 31 December 2017) and their respective ratios per 1 000 population

Cluster	Doctors	Ratio to overall population	Ratio to population aged 65+	Nurses	Ratio to overall population	Ratio to population aged 65+	Allied health staff	Ratio to overall population	Ratio to population aged 65+	General beds	Ratio to overall population	Ratio to population aged 65+	Catchment districts
Hong Kong East Cluster	610	0.8	4.0	2 769	3.6	18.1	834	1.1	5.4	2 105	2.8	13.7	Eastern, Wan Chai, Islands (excluding Lantau Island)
Hong Kong West Cluster	652	1.3	6.9	2 888	5.5	30.5	975	1.9	10.3	2 860	5.5	30.2	Central & Western, Southern
Kowloon Central Cluster	1 170	1.0	5.3	5 209	4.5	23.7	1 579	1.4	7.2	4 874	4.2	22.2	Kowloon City, Yau Tsim Mong, Wong Tai Sin
Kowloon East Cluster	687	0.6	3.9	2 873	2.5	16.2	790	0.7	4.4	2 405	2.1	13.5	Kwun Tong, Sai Kung
Kowloon West Cluster	993	0.7	4.2	4 226	3.1	18.0	1 261	0.9	5.4	3 431	2.5	14.6	Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island
New Territories East Cluster	972	0.7	5.0	4 249	3.2	21.9	1 283	1.0	6.6	3 730	2.8	19.2	Sha Tin, Tai Po, North
New Territories West Cluster	808	0.7	5.4	3 613	3.1	24.3	1 019	0.9	6.9	2 596	2.3	17.5	Tuen Mun, Yuen Long
Cluster Total	**5 894**	**0.8**	**4.8**	**25 827**	**3.5**	**21.1**	**7 742**	**1.0**	**6.3**	**22 001**	**3.0**	**18.0**	

Notes:

1. The above population figures are based on the latest revised mid-year population estimates by the Census & Statistics Department and the latest projection by the Planning Department. Individual figures may not add up to the total due to rounding and inclusion of marine population.
2. The ratios of doctors, nurses, allied health professionals and general beds per 1 000 population vary among clusters and the variances cannot be used to compare the level of service provision directly among the clusters because:
   (a) in planning for its services, the Hospital Authority has taken into account a number of factors, including the increase of service demand as a result of population growth and demographic changes, advancement of medical technology, manpower availability as well as organization of services of the clusters and hospitals and the service demand of local community. Population is only one of the factors considered;
   (b) patients may receive treatment in hospitals other than those in their own residential districts; and
   (c) some specialised services are available only in certain hospitals, and hence certain clusters and the beds in these clusters are providing services for patients throughout the territory.
3. The above bed information refers only to the general beds in HA, while those of infirmary, mentally ill and mentally handicapped beds are not included given their specific nature.
4. The manpower figures are calculated on full-time equivalent basis including permanent, contract and temporary staff in HA. Individual figures may not add up to the total due to rounding.
5. The number of "doctors" does not include interns and dental officers.

Source: Information extracted from the Administration's replies to Members' initial written questions during examination of estimates of expenditure 2018-2019

醫院管理局 HOSPITAL AUTHORITY 新聞稿 PRESS RELEASE

Thursday, 14 March 2019

Attention News Editors:

In response to media enquiries on the meeting with representatives of Association of Hong Kong Nursing Staff (AHKNS) this morning, the spokesperson for Hospital Authority (HA) made the following reply today (14 March):

HA has all along been very concerned about the heavy workload that frontline nurses are facing. HA met with the representatives of AHKNS this morning and explained the measures taken to relieve the workload of frontline nurses. The measures include recruiting more nurses apart from the existing establishment; increasing promotion posting; significantly increasing the training places for sponsored enrolled nurse to undertake registered nurses conversion programmes; employing more part-time nurses in short-term and offering an additional incremental salary point for those nurses who have attained the requirements as specialty nurses.

In the year of 2018-19, HA has already recruited over 2,400 nurses, exceeding the original target of 2,230. In addition, the recruitment target of the next year which is set to be 2,270 is expected to be exceeded. HA will continue to recruit nurses after replenishing wastage and manpower for new services. Additional manpower will hopefully relieve frontline workload.

Furthermore, HA will increase promotion posts to retain staff in the year of 2019-20. 350 posts of Advance Practice Nurse will be added to enhance senior coverage at night. 10 positions Nurse Consultants will also be added. With regard to clerical support, 200 additional ward clerks will be recruited to enhance clerical support and coverage. HA will continue to employ part-time nurses to alleviate the work pressure of frontline nurses in the interim.

With additional funding support from the Government, HA will offer an additional incremental salary point to those registered nurses who have attained the requirements as specialty nurses to encourage professional development of nursing care with details to be announced soon.

Regarding the proposal raised by AHKNS on salary review of nursing staff such as enrolled nurse salary and on resumption of previous pay scale, HA will cautiously study the impact of the proposal with the Government, in particular the financial feasibility. In addition, HA will significantly increase the training places by 50% for sponsored enrolled nurse to undertake registered nurses conversion programmes.

Given the diversed views with regard to shift arrangement for nurses, HA will continue to liaise with them for arriving at a consensus .

HA expresses gratitude to the AHKNS for their suggestions raised at the meeting and will maintain a close communication with nursing staff groups.

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醫院管理局 HOSPITAL AUTHORITY 新聞稿 PRESS RELEASE

Appendix III

Thursday, 28 February 2019

Hospital Authority welcomes Government's additional resources for retaining staff

The Hospital Authority Board (HA) Administrative and Operational Meeting discussed the Government Budget 2019-20 today (28 February). The HA Board welcomed the government's increased financial provision to HA as well as the additional resources allocated for staff retention measures. Among the $68.8 billion recurrent financial provision, $720 million will be utililised in various staff retention measures.

"We are thankful to the Government for helping us retain staff. HA will utilise this additional funding prudently. We have already formulated various staff retention measures. The measures will be implemented after the required funding process is completed," the HA Chairman, Professor John Leong Chi-yan said.

HA proposed the staff retention measures as follows:

- To increase the Fixed Rated Honorarium (FRH) for Doctors to boost staff morale. Around 4,800 doctors are eligible;
- To upgrade Advanced Practice Nurse posts to enhance night shift supervision and senior to junior ratio;
- To encourage nursing professional development, an increment will be granted to nurses who have attained specialty qualification;
- To increase the number of promotional posts for pharmacists so that the senior to junior ratio can be improved;
- To recruit more ward executive assistants to alleviate clerical works of healthcare workers;
- To reduce attrition, salary of supporting staff will be increased. Around 16,000 supporting staff will be benefited;
- Continuation of the Special Retired and Rehire Scheme to attract more retired healthcare workers to rejoin public hospitals and help train younger healthcare workers.

"We propose to implement the measures as early as practicable after the Legislative Council Finance Committee has approved the required funding. The HA Board also approved in principle effecting enhancements on supporting staff's salary and doctors' FRH from 1 April this year," HA Chief Executive, Dr Leung Pak-yin said.

HA Board approved the abovementioned staff retention measures in principle. Detailed implementation plans will be deliberated by respective functional committees.

Apart from staff retention measures, the Government also allocated additional funding to support HA to further enhancing Special Honorarium Scheme in the coming service surge period.

Professor Leong expressed gratitude to all staff again for their commitment to serve patients, amid the manpower shortfall.

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Appendix IV

Relevant papers on operation and manpower 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)
	18.1.2016 (Item V)	Agenda Minutes
	20.6.2016 (Item II)	Agenda Minutes CB(2)261/16-17(01)
	26.1.2017 (Item I)	Agenda Minutes
	19.6.2017 (Item IV)	Agenda Minutes
	4.7.2017 (Item I)	Agenda Minutes
	16.10.2017 (Item IV)	Agenda Minutes
	15.1.2018 (Item III)	Agenda Minutes CB(2)1857/17-18(01)
	19.3.2018 (Item IV)	Agenda Minutes CB(2)1261/17-18(01)
	15.10.2018 (Item III)	Agenda

* Issue date

Council Business Division 2
Legislative Council Secretariat
18 March 2019