Annex 2

Report of the Public Engagement Programme

Part One: Introduction

1.1 The services provided by HA touch on every sector of the community. Engagement of stakeholders like HA staff, patient groups as well as the wider public will help provide useful inputs to the review of HA. The SC has therefore conducted a Public Engagement Programme to gauge the public views on HA.

1.2 A consultant has been engaged to assist in the conduct of the Public Engagement Programme through meetings, visits, focus group discussions, individual engagement sessions and public fora.

1.3 This report sets out the process of and the views collected in the Public Engagement Programme. Part Two of the report outlines the scope of the programme, Part Three summarises the views collected and Part Four gives the final remarks.

Part Two: Scope of the Public Engagement Programme

Engagement Activities

2.1 The Public Engagement Programme ran from January to July 2014. During this period, the SC had conducted a series of activities, namely –

(a) SC Members held meetings with four major medical and patients' groups in January 2014. These stakeholders are the Hong Kong Medical Association, HKAM, Hong Kong Patients' Rights Association of the Society for Community Organisation, and Hong Kong Alliance of Patients' Organisations;

(b) the SC visited HAHO and each of its seven clusters to meet with the HA Board, HAHO staff, cluster management and cluster staff from February to April 2014;

(c) the SC held stakeholders' fora in March 2014. A total of 27 organisations, comprising five medical bodies, seven nursing bodies, 11 allied health bodies and four patient groups took part in three sessions of fora;

(d) the Public Engagement Programme consultant had luncheon meetings with opinion leaders in May 2014. A total of five sessions of luncheon had been held for these opinion leaders including community leaders, academics and researchers, columnists, electronic media programme hosts, and other media professionals;

(e) the Public Engagement Programme consultant conducted focus group sessions with representatives from major stakeholders in June 2014. These major stakeholders came from patient groups, healthcare professional bodies, healthcare related NGO, the HGC and the RAC of HA. In view of the large number of the major stakeholders of HA, we had adopted a stratified random sampling method to select participants for each focus group within the pool of major stakeholders (please see **Appendix A** for details). A total of 42 representatives from seven patients groups, 12 healthcare professional bodies, ten healthcare related NGOs, and ten Members of HGC and RAC had separately joined four sessions of focus group discussions; and

(f) the SC conducted public fora in July 2014 with one held in each of

the three regions in Hong Kong Island, Kowloon and the New Territories. A total of 350 members from the public participated in the fora. Participants came from diverse background, including those from Kai Fong Associations, District Councils, patient or concern groups, HA staff and ordinary members of public.

The full list of the engagement activities is in **Appendix B**.

2.2 We have undertaken a simple questionnaire survey in the public fora to gauge the participants' overall views on HA. According to the survey, respondents gave a score of 6.3 and 7.0, out of 10.0, for the quality of healthcare services and professionalism of healthcare programme respectively, showing their general positive view of HA's services. The detailed findings of the questionnaire survey are at **Appendix C**[35].

2.3 To publicise the Public Engagement Programme and to invite public participation, we have prepared a number of publicity activities –

(a) leaflets distributed in public hospitals;

(b) advertisements placed in major newspapers;

(c) posters displayed in public hospitals, District Offices and Community Halls; and

(d) dedicated page under the FHB's website.

2.4 We have also received comments from certain stakeholders through emails, petitions, and letters direct, which have been duly incorporated together with views gathered in the engagement activities in this report.

2.5 The full list of stakeholders who have provided written views to us is at **Appendix D**.

[35] It should be noted that there were constraints in the conduct of the survey through this questionnaire. Firstly, participants in the fora were not a random sample selected to represent the general public. Secondly, the possibility that a respondent might have attended more than one forum and returned the questionnaire more than once could not be precluded. As such, the findings from this survey should be interpreted with caution.

Part Three: Analysis of Views Received

3.1 We have broadly classified the views received during the Public Engagement Programme into the following six areas, which are in line with the priority areas of review of the SC –

(a) Management and organisation structure;

(b) Resource management;

(c) Staff management;

(d) Cost effectiveness and service management;

(e) Overall management and control; and

(f) Others

Management and Organisation Structure

3.2 The first area of stakeholders' views is the management and organisation structure, which is mainly characterised by the HA Board and the cluster arrangement. HA Board governs HA and the cluster arrangement serves as a system under which HAHO plays a leading, policy, coordination and supporting role to its seven clusters and the frontline delivery of healthcare services.

Cluster Arrangement

3.3 Some stakeholders considered that the role of the HA Board, being a managing board, should be enhanced in order to have a more active and effective management of the organisation.

3.4 Stakeholders generally recognised the need for a cluster arrangement for a large organisation like HA.

3.5 However, noting the disparity in size and number of hospitals as well as the high level of cross-cluster activities in the three clusters in the densely populated Kowloon region, there were calls for reviewing the clustering arrangement for the three clusters concerned. Some considered that, in drawing up the cluster boundary, HA should take into account the geographical size of the catchment areas, the demographic characteristics of the population as well as the development of healthcare facilities in the areas.

3.6 In particular, the Wong Tai Sin District Council had been urging the Government to review the cluster boundary so as to provide more rationalised and better coordinated services in the region.

3.7 High cross-cluster utilisation was a concern not only of the District Council or the patients, but also of HA staff. Some staff considered that there was mismatch of services in the three clusters in Kowloon causing problems in referrals and follow-up of cases.

3.8 While some HA staff raised the need for refinement of the cluster arrangement, they cautioned against any drastic revamp of the existing structure or boundary. They pointed out that frontline staff have taken a long time to develop and operate the referral and service coordination arrangement under the existing clustering system. Any substantial changes in cluster delineation would affect integrated service provision, involving referral for follow up treatment, rehabilitation services, and outreaching support, etc. for patients after discharge from hospitals.

Coordination of Services

3.9 Patient organisations raised concerns on the inconsistent practices in service provision in different clusters. Some HA staff opined that all acute hospitals should be equipped with comparable facilities to provide the same basic and standard services to serve the local community, notwithstanding that some acute hospitals were smaller than the others. There were also views that the communication between HAHO, the clusters as well as hospitals should be enhanced to ensure smooth implementation of corporate-wide policies.

3.10 Some HA staff expressed opinions on the dual role of CCE as the head of the cluster and HCE of the major acute hospital therein, citing concerns of possible perception of large hospitals enjoying greater advantages in resource allocation. There were, however, also views that a CCE without the portfolio of a HCE might lack hands-on experience in hospital management and this was not conducive to the CCE's discharge of management responsibilities.

3.11 Some suggested that HA should strengthen its coordination role and enhance communication with clusters and hospitals to ensure consistent standard of service and better manpower deployment across clusters/hospitals.

Resource Management

3.12 The second area of stakeholders' views is resource management. HA manages some $50 billion a year and stakeholders have expressed various views on the way such resources should be managed.

Resource Allocation Model

3.13 There were quite a significant number of views expressing concerns on the existing resource allocation model and showing support for a population-based resource allocation approach. The general perception was that the present model was unfair as the resource allocated to a cluster were not commensurate with service demand which was considered to be related to the number of patients and population in a cluster. For example, the resources allocated to KEC were the least among the seven clusters on a per capita basis. Kwun Tong and Sai Kung districts covered by KEC accounted for 15.1% of Hong Kong's overall population in 2013. While 15.5% of HA's patients had ever used KEC service, KEC was only allocated with 10.7% of the total recurrent funding allocated to clusters in 2013-14.

3.14 Some considered that the present resource allocation model often focused only on new money for implementing new services, leaving the inherent "unfairness" in baseline provision among clusters unaddressed. Many thought that the population-based resource allocation model would provide a fairer and more transparent mechanism in allocating resources. It would allow resources to match the prevailing service needs rather than historical provision.

3.15 Others however had concerns about a resource allocation model solely based on population size. Specifically, some were worried that a pure population-based model would not be able to take into account the territory-wide tertiary and quaternary services provided by certain hospitals in selected clusters, the inflow demand for cross-cluster services experienced by certain clusters and the special role of certain hospitals (e.g. teaching hospitals shouldering additional teaching duties on top of service provision). For example, Queen Mary Hospital provided liver transplant services for patients throughout the territory. It also served as a teaching hospital of the Faculty of Medicine of the University of Hong Kong. The same applied to the Prince of Wales Hospital as a teaching hospital for the Chinese University of Hong Kong's Medicine Faculty. The Hong Kong Eye Hospital at KCC, as another example, served a large number of patients from other clusters.

3.16 Moreover, the resident population in a district did not truly reflect patients' behaviour in seeking medical services as one might choose to receive services from clusters other than the one he/she resided after considering factors like the distance from the workplace, transportation convenience reasons and personal preference.

3.17 Some considered that the resource allocation for the two clusters in the New Territories should take into account the service demand for healthcare services from the cross-border patients.

Procedures in Resource Allocation

3.18 Some HA staff raised concerns on the tedious and complicated procedures involved in bidding new resources. Some were particularly uneasy with the requirement to obtain clearance from numerous committees and hierarchies at hospital, cluster and HAHO levels for implementing a new initiative, and the requirement to repeat the whole process again next year if the bid in the current year failed. All these have added to the workload of frontline clinical staff. Some, however, appreciated the merits of clearing the proposals with the COC for the relevant specialty to ensure consistency and coherence in service provision at the corporate level.

3.19 Some staff were also concerned that the decision-making process of resource allocation was not as transparent as they expected and they did not have a full picture on the rationale and methodology adopted. There was perception that large hospitals might have advantage as COC chairmen normally came from large hospitals. Some claimed that the amount of resources actually allocated to frontline services was less than the original approved amount and thus became inadequate, alleging that part of the sum had been used to meet the supporting functions of HAHO and cluster management.

Staff Management

3.20 The third area of stakeholders' views concerns with staff management. HA has some 70,000 staff and the way HA deals with its human resources management has attracted a number of views, particularly from its staff.

Staff management

3.21 The general sentiments from frontline staff were that there was room for improvement in HR practices. For example, inconsistencies in HR practices among clusters were observed. Some pointed out that different cluster had

different arrangement for the granting of study leave and creation of posts. Some considered that HAHO should be equipped with greater authority in coordinating resource deployment and setting direction. In particular, to enhance the collaborative culture within the organisation, HA should consider more staff rotations. HAHO should also attend and oversee the promotion boards of individual clusters to ensure transparency and fairness.

3.22 While different hospitals in the same cluster would perform different roles, some considered that a more flexible flow of staff between clusters/hospitals would provide staff with more training opportunities and exposure and this would help attract and retain staff.

3.23 Some also thought that at present, the spirit of cooperation in providing manpower support between clusters or hospitals was not strong enough in meeting *ad hoc* requirements for additional manpower. There should be some central coordination at HAHO level in deployment of staff across clusters to meet short-term service needs, particularly during crisis or contingent situations.

3.24 Acknowledging the fact that certain specialties might be more popular among medical graduates than others, some opined that more central coordination was needed in the allocation of Resident Trainees to address manpower shortage in these specialties.

3.25 Some, however, saw the merits of allowing individual clusters or hospitals to retain the authority to select staff for them to build their own team. In general, supporting grades were more cautious to centrally-coordinated promotion or transfer as they might not wish to work in other clusters due to possible concerns on transportation and the need to adapt to a new working environment.

Training

3.26 Some staff raised their concerns on the shortened training time and reduced overseas training opportunities and the lack of transparency in the selection process. There were also views that HA should strengthen collaboration with its strategic partner, e.g. HKAM, in planning and developing training programmes and that sufficient resources should be earmarked for performance of training duties as well as facilitating staff relief.

3.27 Some considered that the current operation in HA over-emphasised service delivery but overlooked the need to upgrade professionalism. There was a need to enhance training so as to improve the quality of services provided by

healthcare staff. To enhance planning on training matters, some suggested the establishment of a committee on training under the HA Board and a dedicated budget for training purposes.

Cost Effectiveness and Service Management

3.28 The fourth area of stakeholders' views concerns with cost effectiveness and service management. Some stakeholders expressed a number of views on the appropriate way for HA to deliver services at a cost-effective manner and manage services through an optimal service delivery model.

Cost Effectiveness

3.29 Stakeholders who expressed views on the subject agreed in general that it was important to have a mechanism to ensure cost effectiveness of HA's service delivery.

3.30 Some considered that the role of HA Board should be enhanced as a managing board in order to manage and monitor HA's performance more effectively. Some clinical staff, on the other hand, voiced concerns that KPIs had added burden to their workload with many reporting requirements and administrative duties so generated.

Service Quality

3.31 As far as service quality was concerned, the area that stakeholders were most interested in was the level of or accessibility to services. Some considered that the long waiting time, particularly in SOPC, was the single most important problem of HA. Others found A&E and inpatient services insufficient as well and the resulting long time that a patient had to wait at A&E departments before getting admitted into an inpatient ward (the "access block" problem) was unsatisfactory.

3.32 Some attributed the difficulties in alleviating the waiting time problem to the lack of coordination and sectarianism among specialty services or clusters.

3.33 Some patients considered that the telephone appointment system for GOPC was not easy to use, particularly for elderly patients. The quota for GOPC was not sufficient to cater for the demand of the public either.

3.34 Some were concerned with the long waiting time for drug dispensing in pharmacies.

3.35 All in all, stakeholders called for enhanced level of services in various aspects in order to meet the rising demand.

Mode of Service Delivery

3.36 Stakeholders in general found that HA had to consider an appropriate way to manage the growing demand for healthcare services. Some considered that HA should enhance its work on rehabilitation services and extended care services in view of the ageing population and increasing chronic diseases.

3.37 Some considered that HA should consider strengthening step-down care and community partnership such as collaboration with the welfare sector to minimise the need for admissions to hospitals. Enhancing support through, for example, services of day centres or home visits to patients could facilitate early discharge of patients with stable medical condition and alleviate the overcrowded Medical wards in hospitals. Some considered that HA should collaborate with the private sector so as to make use of the spare capacity of the latter through more PPP programmes.

3.38 Some found that the GOPC services should be enhanced so as to alleviate the pressure on A&E departments. HA should draw up plans to monitor the service demands in different point of service delivery and adjust and enhance service capacity as appropriate. New service delivery model through, say, reviewing the arrangement for acute and convalescent wards, should also be considered to cater for the medical needs of elderly patients. Meanwhile, the working relationship with the Department of Health should be strengthened so as to provide holistic and better services for the public.

3.39 Some suggested that HA should enhance communication with patients and strengthen mechanism to engage patients for feedbacks in order to facilitate service planning and improvement.

Overall Management and Control

3.40 The fifth area of stakeholders' views is overall management and control. This is related to how HA maintains its risk management and internal control system to ensure that quality public healthcare services are provided.

3.41 Some members of the public were concerned with the medical incidents that happened from time to time. They called for a more transparent and stringent clinical governance system to ensure the quality and safety of services.

3.42 Some clinical staff pointed out that while the COS in some specialties carried out merely administrative functions, others adopted a more proactive role in clinical monitoring and governance. The different approach by individual COS would affect training and adoption of advanced technology and treatment protocol in different specialties in different hospitals. They considered that the role of COS should be clearly defined particularly in respect of clinical governance given the team work nature of many clinical duties.

3.43 Some expressed concern over the layering of specialties/services committees including COC/CC/HAHO level committees and the Board committees. Such arrangement resulted in time consuming processes and more administrative work for clinical staff in seeking endorsement from each of these layers before any service proposals could be implemented. Clinicians saw some scope for streamlining the consultation process to facilitate timely clinical service development in HA to take account of changing service needs and/or medical technology.

Other Views

3.44 During the Public Engagement Programme, stakeholders have raised a wide range of views concerning policy matters relating to the healthcare system in Hong Kong as well as operational matters of HA (please see **Appendix E** for a summary of such views). While not all these views fall within the scope of the Review by the SC, we have taken note of them and will make reference to them when considering the respective policy areas. And for views related to the specific operational aspects in HA, we have relayed them to HA for consideration as appropriate.

Part Four: Final Remarks

4.1 Throughout the Public Engagement Programme, stakeholders, both within and outside HA, have been enthusiastic in voicing their views on HA. While they have pointed out a number of areas for further improvement, most stakeholders appreciated the efforts of HA in providing a wide range of healthcare services to the public at a low cost.

4.2 We thank the views of all stakeholders and have taken due account of their views in formulating the recommendations in the Review on HA.

Appendix A to Annex 2

The Mechanism in Forming the Focus Group

Objective of Focus Group Discussions

We have held focus group discussions to solicit the in-depth views of major stakeholders on HA.

2. In view of the large number of major stakeholders of HA, we have adopted a stratified random sampling method to select participants for each focus group. The sampling method involved partitioning the population of major stakeholders into strata (or homogenous groups) and selecting samples randomly within each stratum to ensure a balanced representation.

Sampling Procedures

3. We first drew up four lists of major stakeholders with frequent interface with HA as follows –

(A) 7 patient groups;

(B) 48 healthcare related professional bodies;

(C) 30 NGOs with close working relations with HA; and

(D) Chairpersons of all 32 HGC and Members of all three RAC of HA.

We also divided the lists into sub-groups as follows –

Groups of Major Stakeholders	Subgroups	No. of Stakeholders in each subgroup
(A) Patient groups	(A1) Alliance of patient groups	3
	(A2) Individual patient groups	4
(B) Healthcare related professional bodies	(B1) Medical professional groups	9
	(B2) Nursing professional groups	13
	(B3) Allied health professional groups	26

Groups of Major Stakeholders	Subgroups	No. of Stakeholders in each subgroup
(C) NGOs with close working relations with HA	(C1) Composite bodies	22
	(C2) Rehab and hospice services	4
	(C3) Specific diseases/disabilities	4
(D) Chairpersons of HGCs and Members of RACs of HA	(D1) HGC chairpersons of hospitals with A&E Service under Schedule 1 to the HA Ordinance (Cap 113)	9
	(D2) HGC chairpersons of hospitals with A&E Service under Schedule 2 to the HA Ordinance (Cap 113)	6
	(D3) HGC chairpersons of hospitals without A&E Service under Schedule 1 to the HA Ordinance (Cap 113)	4
	(D4) HGC chairpersons of hospitals without A&E Service under Schedule 2 to the HA Ordinance (Cap 113)	12
	(D5) Members of Hong Kong RAC*	14
	(D6) Members of Kowloon RAC*	21
	(D7) Members of New Territories RAC*	16

* excluding members who are concurrently HGC Chairpersons.

4. We then drew up ten to 14 participants from each group for focus group discussions along the ways in the ensuing paragraphs.

(A) Patient groups

5. We invited two representatives from each of the alliance of patient groups (sub-group (A1)) and one representative from each of the individual patient groups (sub-group (A2)) to attend the focus group discussion on 6 June 2014. The detailed distribution of invitees and attendees is as follows –

Name of organisations	No. of representatives invited	No. of representatives attended
(A1) Alliance of patient groups		
(1) Hong Kong Alliance of Patients' Organisations	2	2
(2) Patients' Alliance on Healthcare Reform	2	2
(3) Rehabilitation Alliance Hong Kong	2	2
(A2) Individual patient groups		
(1) Hong Kong Patients' Rights Association of the Society for Community Organisation	1	1
(2) Alliance for Renal Patients Mutual Help Association	1	1
(3) New Life Psychiatric Rehabilitation Association	1	1
(4) Mental Health Association of Hong Kong	1	1
Total no. of participants	**10**	**10**

(B) Healthcare related professional bodies

6. We randomly selected four organisations under each of the three subgroups of healthcare related professional bodies and invited one representative from each organisation to attend the focus group discussion on 13 June 2014. The detailed distribution of invitees and attendees is as follows –

Name of organisations	No. of representatives invited	No. of representatives attended
(B1) Medical professional groups		
(1) HKAM	1	1
(2) Public Consultant Doctors Group	1	1
(3) Li Ka Shing Faculty of Medicine, The University of Hong Kong	1	1
(4) Faculty of Medicine, The Chinese University of Hong Kong	1	1
(B2) Nursing professional groups		
(1) Association of Hong Kong Nursing Staff	1	1

Name of organisations	No. of representatives invited	No. of representatives attended
(2) Nursing Council of Hong Kong	1	1
(3) Nurses Branch, Hong Kong Chinese Civil Servants' Association	1	1
(4) Hong Kong Public Nurses Association	1	1
(B3) Allied health professional groups		
(1) Hong Kong Radiographers' Association	1	1
(2) Government Medico-Radiological Equipment Technical Staff Association	1	1
(3) Hong Kong Society of Certified Prosthetist-Orthotists	1	1
(4) Union of Hong Kong Speech Therapists (Medical)	1	1
Total no. of participants	**12**	**12**

(C) NGOs with close working relations with HA

7. We invited four organisations from each of the subgroups of NGOs with close working relations with HA and invited one representative from each organisation to attend the focus group discussion on 20 June 2014. The detailed distribution of invitees and attendees is as follows –

Name of organisations	No. of representatives invited	No. of representatives attended
(C1) NGOs as composite bodies		
(1) Methodist Centre	1	1
(2) Aberdeen Kai-fong Welfare Association Social Service Centre	1	1
(3) Po Leung Kuk	1	1
(4) Evangelical Lutheran Church Social Service - Hong Kong	1	1
(C2) NGOs as rehab and hospice service		
(1) Hong Kong Cheshire Home Foundation	1	1
(2) The Hong Kong Society for Rehabilitation	1	1
(3) Rehabaid Society	1	1
(4) Society for the Promotion of Hospice Care	1	1

Name of organisations	No. of representatives invited	No. of representatives attended
Care		
(C3) NGOs on specific diseases/disabilities		
(1) The Hong Kong Tuberculosis, Chest and Heart Diseases Association	1	0
(2) Lions Kidney Education Centre and Research Foundation, Chan Wong Sau Wah Memorial Renal Dialysis Centre	1	1
(3) Hong Kong Kidney Foundation, Jockey Club Dialysis Centre	1	0
(4) Society for the Relief of Disabled Children	1	1
Total no. of participants	**12**	**10**

(D) Chairpersons of HGCs and Members of RACs

8. We randomly selected two representatives from each of the seven subgroups of HGC chairpersons and RAC members to attend the focus group discussion on 27 June 2014. The detailed distribution of invitees and attendees is as follows –

Subgroups	No. of Members invited	No. of Members attended
(1) HGC Chairperson of 9 Schedule 1 hospitals with A&E service	2	2
(2) HGC Chairperson of 6 Schedule 2 hospitals with A&E service	2	2
(3) HGC Chairperson of 4 Schedule 1 hospitals without A&E service	2	2
(4) HGC Chairperson of 12 Schedule 2 hospitals without A&E service	2	2
(5) 14 Members of Hong Kong RAC (excluding Chairpersons of HGC)	2	1
(6) 21 Members of Kowloon RAC (excluding Chairpersons of HGC)	2	1
(7) 16 Members of New Territories RAC (excluding Chairpersons of HGC)	2	0
Total no. of participants	**14**	**10**

Appendix B to Annex 2

List of Activities in the Public Engagement Programme

A) Meetings with Stakeholders

1.	13 January 2014	Hong Kong Medical Association
2.	13 January 2014	HKAM
3.	21 January 2014	HA Board
4.	21 January 2014	Staff of HAHO
5.	29 January 2014	Hong Kong Patients' Rights Association of the Society for Community Organisation
6.	29 January 2014	Hong Kong Alliance of Patients' Organisations

B) Visits to Clusters of HA

1.	24 February 2014	
	Session I	NTWC Management
	Session II	NTWC Staff
2.	7 March 2014	
	Session I	HKWC Management
	Session II	HKWC Staff
3.	13 March 214	
	Session I	KEC Management
	Session II	KEC Staff
4.	14 March 2014	
	Session I	NTEC Management
	Session II	NTEC Staff
5.	25 March 2014	
	Session I	KCC Management
	Session II	KCC Staff
6.	31 March 2014	
	Session I	HKEC Management
	Session II	HKEC Staff
7.	1 April 2014	
	Session I	KWC Management
	Session II	KWC Staff

C) Fora for Stakeholders

1. 6 March 2014

   Session I — Medical professionals bodies

   (a) Association of Private Medical Specialists of Hong Kong
   (b) Frontline Doctors' Union
   (c) Hong Kong Doctors Union
   (d) Hong Kong Public Doctors' Association
   (e) Public Consultant Doctors Group

   Session II — Nursing professionals bodies, Allied health professionals bodies and patient group

   (a) Association of Hong Kong Nursing Staff
   (b) Midwives Council of Hong Kong
   (c) Nursing Council of Hong Kong
   (d) Hong Kong Pharmacists (Public Service) Association
   (e) Hong Kong Physiotherapy Association
   (f) Hong Kong Physiotherapists' Union
   (g) AIDS Concern

2. 24 March 2014 — Nursing professionals bodies, Allied health professionals bodies and patient groups

   (a) Nurses Branch, Hong Kong Chinese Civil Servants' Association
   (b) Hong Kong Nurses General Union
   (c) College of Nursing, Hong Kong
   (d) The Provisional Hong Kong Academy of Nursing
   (e) Division of Clinical Psychology, The Hong Kong Psychological Society
   (f) Hong Kong Radiographers' Association
   (g) Hong Kong Dietitians Association
   (h) Hong Kong Clinical Psychologists Association
   (i) Hong Kong Occupational Therapy Association
   (j) Hong Kong Association of Medical Physics
   (k) Hong Kong Society of Audiology
   (l) Association of Scientific Officers (Medical)
   (m) Rehabilitation Alliance Hong Kong
   (n) Patients' Alliance on Healthcare Reform
   (o) The Patients and Healthcare Professionals Rights Association

D) Luncheon Meetings

1. 5 May 2014 — 6 print media columnists
2. 9 May 2014 — 6 media professionals
3. 16 May 2014 — 5 opinion/community leaders
4. 26 May 2014 — 6 electronic media programme hosts
5. 29 May 2014 — 6 academics and researchers

E) Focus Groups

1. 6 June 2014 — Patient groups
   - (a) Hong Kong Patients' Rights Association of the Society for Community Organisation
   - (b) Hong Kong Alliance of Patients' Organisations
   - (c) Patients' Alliance on Healthcare Reform
   - (d) Rehabilitation Alliance Hong Kong
   - (e) Alliance for Renal Patients Mutual Help Association
   - (f) New Life Psychiatric Rehabilitation Association
   - (g) Mental Health Association of Hong Kong
2. 13 June 2014 — Healthcare related professional bodies
   - (a) HKAM
   - (b) Public Consultant Doctors Group
   - (c) Li Ka Shing Faculty of Medicine, The University of Hong Kong
   - (d) Faculty of Medicine, The Chinese University of Hong Kong
   - (e) Association of Hong Kong Nursing Staff
   - (f) Nursing Council of Hong Kong
   - (g) Nurses Branch, Hong Kong Chinese Civil Servants' Association
   - (h) Hong Kong Public Nurses Association
   - (i) Hong Kong Radiographers' Association
   - (j) Government Medico-Radiological Equipment Technical Staff Association
   - (k) Hong Kong Society of Certified Prosthetist-Orthotists
   - (l) Union of Hong Kong Speech Therapists (Medical)
3. 20 June 2014 — NGO with close working relations with HA
   - (a) Methodist Centre
   - (b) Aberdeen Kai-fong Welfare Association Social

Service Centre
(c) Po Leung Kuk
(d) Evangelical Lutheran Church Social Service - Hong Kong
(e) Hong Kong Cheshire Home Foundation
(f) The Hong Kong Society for Rehabilitation
(g) Rehabaid Society
(h) Society for the Promotion of Hospice Care
(i) Lions Kidney Education Centre and Research Foundation, Chan Wong Sau Wah Memorial Renal Dialysis Centre
(j) Society for the Relief of Disabled Children

4. 27 June 2014 — Chairpersons of Hospital Governing Committees and Members of Regional Advisory Committees of HA

F) Public Fora

1. 7 July 2014 — Forum in Kowloon
(held in Henry G. Leong Yau Ma Tei Community Centre, Multi-purpose Hall, 1/F., 60 Public Square Street, Yau Ma Tei)
154 individuals attended

2. 14 July 2014 — Forum in New Territories
(held in Tai Po Community Centre, Multi-purpose Hall, 1/F., 2 Heung Sze Wui Street, Tai Po)
118 individuals attended

3. 19 July 2014 — Forum on Hong Kong Island
(held in Causeway Bay Community Centre, Multi-purpose Hall, 3/F., 7 Fook Yum Road, North Point)
78 individuals attended

Findings of the Questionnaires at Public Fora

Introduction

To gauge the general views of the participants of the public fora, we invited all participants to fill in a questionnaire (a copy of which is at Enclosure). In addition to the general demographics and the frequency of visits to HA facilities, the questionnaire asks respondents to give a score to indicate their satisfaction levels of HA's performance in various areas. Respondents may also provide written views in response to an open-ended question in the questionnaire.

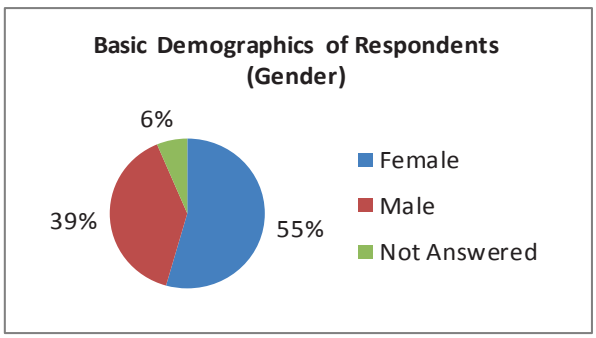
2. Out of the 350 participants, we have received a total of 204 copies of returned questionnaires.

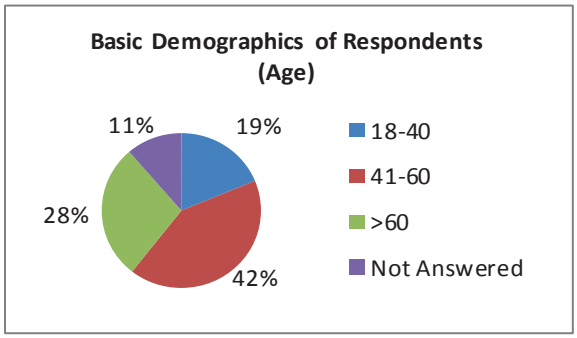
3. It should be noted that the findings of the survey should be looked at with care. The participants in the fora were not a random sample drawn to represent the general population, and hence the views of the former revealed from the survey should not be regarded as representative of that of the latter.

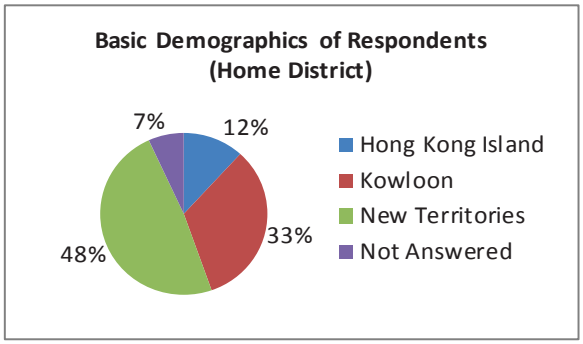
Findings

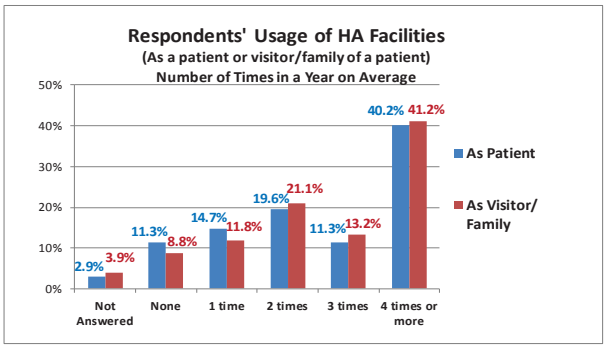
(a) Respondents' Basic Demographics and Usage of HA Services

4. Respondents' demographic information is shown in the following charts –









5. It may be noted that more than 70% of respondents have themselves visited or used HA's facilities twice or more in a year. In a way this shows that the respondents are informed users who have first-hand experience when commenting on HA's services.

(b) Respondents' Satisfaction Levels of Various Aspects of Services

6. The average scores on the satisfaction level of HA's services on seven service aspects are as follows –

Service Aspects	**Average Scores**
(a) Quality of Healthcare Services	6.3
(b) Professionalism of Healthcare Personnel	7.0
(c) Attitude of Healthcare Personnel	6.2
(d) Level of Fees & Charges	7.5
(e) Medicine Provided	6.5
(f) Waiting Time for Services	3.5
(g) Delineation of Clusters in HA	5.2

Note: 0 indicates very unsatisfactory, 5 average and 10 very satisfactory

7. Most aspects record an average score of greater than 5, showing that the respondents generally find HA's services satisfactory. Among the seven aspects covered in the questionnaire, "Professionalism of Healthcare Personnel" and "Level of Fees & Charges" have the highest average scores (7.0 and 7.5 respectively).

8. "Waiting Time for Services", on the other hand, has recorded a score of 3.5 and is the only aspect with a score that is below average. This shows that waiting time is an aspect where respondents are most dissatisfied with.

(c) Respondents' Satisfaction Levels of Various Types of Services

9. The average scores on the satisfaction level of HA's types of services are as follows –

Types of Services	Average Scores
(a) GOPC services	5.4
(b) SOPC services	5.9
(c) A&E services	5.0
(d) Inpatient services	6.6
(e) Ambulatory services	6.4
(f) Community Nursing services	5.8

Note: 0 indicates very unsatisfactory, 5 average and 10 very satisfactory

10. All types of services record an average score of 5.0 or above, indicating that the respondents in general are satisfied with HA's services. It may be noted that while respondents are more satisfied with inpatient services and ambulatory services (with a score of 6.6 and 6.4 respectively), they are less so with A&E services (with an average score of 5.0).

(d) Respondents' Comments on the Open-ended Question

11. Out of the 204 questionnaires received, 110 responded to the open-ended question, giving a total of 190 comments. The areas to which the comments are related may be classified as follows –

Areas	Number of Comments
Management & Organisation Structure	6
Resource Management	5
Staff Management	35
Cost Effectiveness and Service Management	118
Overall Management & Control	0
Others	26
Total	**190**

12. Cost effectiveness and service management, including the service level and accessibility, is an area that most respondents commented on. In this area, respondents have called for improvement in waiting time, GOPC services, elderly services and mental health services, etc.

13. Staff management is an area which receives the second largest number of written comments. Respondents have expressed concerns on the manpower shortage which HA is encountering and have made suggestions for HA to improve the working conditions to attract and retain staff.

14. In other areas, a handful of respondents have mentioned about the need to review the delineation of clusters and improve resource allocation within HA.

HA Review Public Forum - Questionnaire

Sex： _____ Age： _____

Home District： _____ Work District： _____

Part One: Your opinion on services of Hospital Authority

1）In general, are you satisfied with the performance of HA in the following areas?

Rate in scale of 0 to 10 0 for very unsatisfactory 5 for average
10for very satisfactory X for no comment or not applicable

(a) Quality of healthcare services	☐
(b) Professionalism of healthcare personnel	☐
(c) Attitude of healthcare personnel	☐
(d) Level of fees and charges	☐
(e) Medicine provided	☐
(f) Waiting time for services	☐
(g) Delineation of clusters in HA	☐

2）Are you satisfied with the following types of services provided by HA?

Rate in scale of 0 to 10 0 for very unsatisfactory 5 for average
10for very satisfactory X for no comment or non-applicable

(a) General Out-patient services	☐
(b) Specialist Out-patient services	☐
(c) Accident and Emergency services	☐
(d) Inpatient services	☐
(e) Ambulatory services	☐
(f) Community nursing services	☐

3）Do you have any other comments on the services of HA?

_____

_____

Part Two: Your personal experience in using HA services

4）On average how many times a year do you, as a patient, use the services of HA?

☐ None
☐ Once
☐ Twice
☐ 3 times
☐ 4 times or more

5）On average how many times a year do you, as a visitor, attend to the facilities of HA to visit or accompany your family or friends to undertake treatment?

☐ None
☐ Once
☐ Twice
☐ 3 times
☐ 4 times or more

Appendix D to Annex 2

List of Stakeholders who have Submitted Written Views

1. AIDS Concern
2. Association of Hong Kong Nursing Staff
3. Coalition of Civil Servants on Medical and Dental Benefits for Civil Service Eligible Persons
4. Concern Group of Medical Resources (NTW) & Tin Shui Wai Community Development Alliance
5. DAB Kwun Tong Branch
6. DAB Yau Tsim Mong Branch
7. HKAM
8. Hong Kong Alliance of Patients' Organisations
9. Hong Kong Doctors Union
10. Hong Kong Medical Association
11. Hong Kong Patients' Rights Association of the Society for Community Organisation
12. Hong Kong Pharmacists (Public Service) Association
13. Hong Kong Physiotherapy Association
14. Joint Conference of Hong Kong Health Care Professional Organisations
15. KEC Staff
16. KWC - Our Lady of Maryknoll Hospital Frontline Staff
17. NTEC - Alice Ho Miu Ling Nethersole Hospital Staff
18. NTEC Staff
19. Patients' Alliance on Healthcare Reform
20. Public Consultant Doctors Group
21. Rehabilitation Alliance Hong Kong
22. Tai Po District Council Member – Ms WONG Pik-kiu, MH, JP
23. Victoria Harbour Association
24. Wong Tai Sin District Council
25. 4 members of the public

Summary of Other Views Collected in the Public Engagement Programme

During the Public Engagement Programme, in addition to subjects covered under the current Review, stakeholders have raised a wide range of views concerning policy matters relating to the overall healthcare system in Hong Kong as well as operational matters of HA. A summary of these views are set out in the ensuing paragraphs.

Views concerning wider Healthcare Issues

Healthcare System

2. There were views that Hong Kong should have a long term healthcare policy. Noting the increasing burden on public healthcare sector particularly the hospital services, some suggested that the Government should adjust the healthcare policy and resources to enhance the primary care services and give more focus on health promotion, prevention and medical rehabilitation. The Government should also review the optimal way in delivering primary care, having regard to the roles of the Department of Health, HA and the private sector.

3. Some suggested that the Government should evaluate the demand on healthcare manpower and facilities for long-term planning to cater for the ageing population and the disease development.

Funding for HA

4. Some considered that the Government should provide more resources for HA to improve its services. Instead of an annual funding, the Government might consider allocating funding for a longer period to facilitate HA's service planning. Some opined that the Government should set aside a fund for use as medical expenditure by HA to meet the increasing medical cost arising from ageing population.

Fees and Charges for Public Healthcare Services

5. Some suggested that the Government might consider reviewing the fees and charges for public medical services in order to manage demand. For instance, the fees for A&E services should be increased to discourage abuse of A&E services.

Views concerning the Operational Matters of HA

Terms of Employment

6. Various grades of staff have voiced concerns on specific measures to improve their working conditions. For example, some opined that the pay and working conditions of certain grades of staff in HA were inferior to those of their counterparts in the private sector, making it difficult for HA to recruit and retain manpower. They suggested various improvement measures, such as reducing the working hours, enhancing pay, improving the over-time allowance and creating more promotion opportunities.

7. Some thought that the medical benefits of HA staff was inferior to those of civil servants and that the services of the staff clinic at HA should be improved. Some suggested that HA should consider allowing staff to retire not on a specified age but within a range of ages to suit the individual needs of staff and also to solve the manpower shortage problem.

Equipment and Facilities

8. There were views that HA should streamline its procurement practices so as to ensure that obsolete medical equipment was replaced and new equipment would be purchased timely. In particular, some considered that the medical equipment (such as Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) scanner) was not up-to-date and failed to meet the technological advancement and expectation of the public. Some considered that hospitals did not have sufficient resources to replace obsolete equipment.

9. Some staff expressed concerns on HA's existing practice of accepting the offer with the lowest price during the procurement process as it might result in acquisition of outdated equipment. They suggested that flexibility should be allowed in the procurement process.

10. Some staff raised concerns about space constraints in selected hospitals which hampered installation of new equipment and smooth operation of clinical services. They called for expedited improvement and maintenance works to enhance operational efficiency.