CHAPTER 3 MAJOR CHALLENGES FACING THE HOSPITAL AUTHORITY

OVERVIEW

3.1 This chapter examines the major challenges facing HA.

MAJOR CHALLENGES

Ageing Population

3.2 While the public hospital services in Hong Kong have been recognised as one of the best in the world, the public healthcare system is facing a major challenge of a rapidly ageing population. In 1993, 9% of our population was aged 65 or above. The percentage increased to 15% in 2014 and is expected to rise further to 26% in 2031 and 30% in 2041. Such a change in composition in our population will impose pressure on the healthcare sector because the demand for healthcare services by elderly is much higher than that by the non-elderly.

Increasing Medical Costs

3.3 With ongoing advances in medical technology, the medical expenditures have been rising rapidly. The annual drug expenditure for HA, for example, rose by 90% from $2.6 billion in 2007-08 to $4.9 billion in 2013-14.

Increasing Demand for Medical Services

3.4 To cope with the service demand, HA's annual expenditure has increased by about 52% during 2007-08 to 2013-14 and is expected to continue to increase in the years to come. Compared to the position as of end March 2014, it is estimated that an additional of 2,300 and 8,800 public hospital beds will be needed by 2021 and 2031 respectively as the population ages at an accelerated pace in the next two decades.

Manpower Shortage

3.5 While the demand for public healthcare services is rising rapidly, HA is facing concurrently a severe problem of manpower shortage, especially of doctors. One of the reasons is a reduction in the number of medical student

intake from some 310 a year in 2001-02 to 280 in 2003-04 and further to 250 in 2005-06 in the aftermath of the Asia financial crisis in the early 2000s. The manpower shortage in HA is further exacerbated by the competing demand for experienced doctors following the rapid expansion of the private healthcare sector in recent years. The situation is expected to improve when the number of medical graduates starts to rise to 320 in 2015 and further to 420 in 2018.

Long Waiting Time

3.6 The high demand on medical services, coupled with the shortage of manpower, has resulted in long waiting time for a number of SOPC services as well as for A&E services. Disparity in waiting time was also observed within HA. The disparity across clusters in some SOPC services such as Ear, Nose and Throat (ENT) and Ophthalmology are particularly conspicuous. The varying waiting time between clusters may be caused by differences in the age profile and demand patterns between different geographical locations. At the same time, there are alleged disparities in resource management and perceived "sectarianism" between clusters. All these have raised concerns and criticisms both in the community as well as within HA despite the fact that HA has initiated pilot cross-cluster referral arrangements for selected SOPC services to partly address the disparity.

High Public Expectation on HA's Role as a Public Healthcare Service Provider

3.7 As a public healthcare service provider, HA is governed by the law and is subject to the principle that no person should be prevented, through lack of means, from obtaining adequate medical treatment. The public has been enjoying highly subsidised and quality healthcare services provided by HA and has high expectation for HA to not only meet the basic demand but to continue to improve its services, e.g. shortening waiting time, introducing new services, expanding the scope of the HA Drug Formulary, etc.

PRIORITY AREAS FOR REVIEW

3.8 Having regard to the present situation and the major challenges faced by HA as set out above, the SC has considered that the following main issues, which have been raised by patient groups, HA staff, the community and other stakeholders, should be the priority areas to be comprehensively examined in the Review.

Management and Organisation Structure

3.9 A key feature of the management and organisation structure of HA is the cluster arrangement, which aims to establish a clear line of accountability for the operations of all hospitals in the cluster, achieve integration and collaboration amongst various clinical services in the cluster, ensure the most cost-effective use of resources within and between clusters, break the boundaries of services/functions (e.g. human resources, supplies chain, facility management), and develop community-based healthcare services with other healthcare providers in the district, etc.

3.10 Noting that a major criticism leveled on the cluster arrangement is the perceived "sectarianism" between clusters and that HA has adopted this cluster arrangement for over a decade, the SC reckons that it is necessary to examine whether the existing cluster management structure needs to be refined to ensure the effective delivery of services and discharge of functions and responsibilities.

Resource Management

3.11 Under the cluster arrangement, HAHO allocates resources to each cluster through a resource management framework that integrates closely with its service planning process, under which resource inputs are linked up with service outputs, targets and quality standard. The use of resources at the cluster level is then monitored and evaluated by HAHO through a financial and performance reporting system.

3.12 The SC notes the frequent complaints that clusters with a higher population base are not given an appropriate proportionate share of the overall budget. It is a fact that resources in HA are not allocated solely based on the population size of the cluster. It nevertheless gives rise to the questions of whether the present resource allocation model provides an objective and fair means in aligning resources to areas of need, and how it should be improved to facilitate better alignment and balancing of resource allocation to meet service/quality gap across respective clusters.

Staff Management

3.13 Human resources are the key asset of HA and account for some 70% of its annual expenditure. A stable and motivated workforce is the foundation for quality healthcare. The SC considers that there is a need to review if the present staffing policy and structure of HA is optimal for attracting, retaining and motivating staff; and what measures and improvements are needed to optimise the

deployment and use of its human resources in light of the growing demand and rising public expectation.

Cost Effectiveness and Service Management

3.14 In response to the increase in demand for public healthcare services and rising medical costs, the Government has increased its annual subvention for HA. In 2015-16, the Government's recurrent subvention to HA amounts to $49 billion, representing a nearly 50% growth from 2010-11. Putting into context, the Government's recurrent subvention to HA accounts for 92% of Government's recurrent expenditure on health and about 15% of the total government recurrent expenditure[10]. On capital subvention, the Government has allocated about $5 billion for acquisition of equipment, information technology systems and capital works projects in 2015-16. Furthermore, the Government has provided a one-off grant of $13 billion in 2013-14 to fund HA's minor works projects for the coming ten years or so, and $1 billion from that grant is expected to be spent in 2015-16. Comparing with the capital subvention in 2010-11, there is a significant increase of $3 billion. With an ageing population, public healthcare expenditure is set to continue rising. It is necessary to have a system to measure and evaluate the output and the performance of HA to assure the public that funds allocated to HA are well spent and managed.

3.15 Waiting time for SOPC services is an important access issue and concern of the community. The SC recognises the need to examine what can be done in this important area of concern of the public.

Overall Management and Control

3.16 Medical incidents are often regarded as an indicator of the quality and safety of the services provided by HA. It is necessary to examine whether the clinical governance system in place in HA is appropriate and whether it is effective in reducing the risk and to provide the necessary assurance for the quality and safety of services to the community and the patients of HA.

3.17 The SC has examined each of these priority areas, with details set out in Chapter 4 to Chapter 8.

[10] With the cumulative growth in the Government's recurrent subvention to HA, the share of health in the total government recurrent expenditure has increased to around 17%.