

CHAPTER 5 RESOURCE MANAGEMENT

OVERVIEW

5.1 As the largest subvented organisation in Hong Kong, HA manages some \$50 billion a year to provide public healthcare services for the community. While the amount of fund available to HA is significant, resources are always finite and the way to manage them effectively and equitably is an important area that needs to be looked into. In addition, while the concept of organising the delivery of frontline clinical services into seven clusters would enable HA to be more able to respond to the demand and demographic characteristic of the local population, it also means that the resource management system inside HA has to address the public, patients and staff perception of fairness, equity and transparency between clusters and to some extent between hospitals within the cluster. This chapter sets out the background of the resources available to HA, the development of internal resource allocation models within HA, and the SC's observations on the models and recommendations for improvement.

5.2 Like many other healthcare providers around the world, HA strives to manage the ever-rising service demand with limited resources. To cope with the continuous emergence of challenges and the changing healthcare service environment, HA's resource management has been evolving over the past 20 years to align resource allocation with areas of need on the basis of three major principles –

- (a) ***Government Healthcare Policy***
To ensure no person should be prevented, through lack of means, from obtaining adequate medical treatment¹³;
- (b) ***Government Funding Arrangements***
To tie in with the Government's funding arrangements for HA; and
- (c) ***Corporate Strategy on Internal Resource Allocation***
To ensure public resources are used effectively to provide services of the highest possible standard within resources obtainable¹⁴, as well as to deliver output/outcome-focused care.

¹³ Principle quoted from HA Ordinance (Cap 113), Section 4 (d).

¹⁴ HA Ordinance (Cap 113), Section 4 (c)(i).

5.3 To fulfill its statutory obligation in providing the highest possible standard of care within resources obtainable, HA strives to uphold its key values in resource management – to facilitate service provision not only to achieve continuum of care within the same geographical proximity for patients seeking medical support, but also to optimise effectiveness of care for patients receiving medical services at HA.

5.4 To this end, HA provides local communities with a comprehensive range of core primary and secondary care services organised into cluster networks of facilities and services. Such services include 24-hour A&E care, inpatient services supported by different specialties, day services, outpatient services and rehabilitation and community services.

5.5 To optimise the effectiveness of medical services from a professional viewpoint, it is also necessary to allocate and utilise resources for the betterment of total patient care. Within each care episode, individual patients may require services from a number of clinical specialties. To cater for patients' multiple needs throughout the course of their illness, different specialty services are organised and provided within each of the acute, extended and community care episodes. Some highly specialised services which require advanced technological support and special scarce expertise (i.e. specialty service networking) are operating across clusters on a territory-wide basis (tertiary level services). These services are centralised at designated centres with a view to facilitating effective pooling of expertise and resources. Examples of such services are neurosurgery, oncology, organ transplants (kidney, liver, heart, lung), bone marrow transplant and burn management services, as well as the Hong Kong Children's Hospital being developed at the Kai Tak Development Area.

5.6 To drive better clinical outcome and efficiency gain, some medical services have also been put under the management of a single cluster to serve the whole Hong Kong population, such as the Blood Transfusion Service at KCC (for ensuring sufficient supply of safe and high-quality blood and blood components for all hospitals' use), and the Infectious Disease Block at KWC (constructed following the 2003 Severe Acute Respiratory Syndrome (SARS) epidemic to better prepare Hong Kong for any future emergent infectious diseases).

5.7 All in all, HA's objectives of resource management are to –

- (a) ensure efficient use of the public resources as stipulated in the HA Ordinance (Cap 113)¹⁵;

¹⁵ HA is under a statutory duty to "use hospital beds, staff, equipment and other resources efficiently to provide

- (b) provide necessary funding to meet cluster/hospital operating commitments;
- (c) support HA and its development to serve the community, in short-term and long-term, through -
 - (i) achieving annual planning and targets committed to the Government under the Resource Allocation Exercise;
 - (ii) timely modernisation of facilities and equipment to meet evolving healthcare needs of the population;
 - (iii) building and retaining a quality healthcare workforce for HA¹⁶ and for Hong Kong at large;
 - (iv) advising the Government of the needs of the public for hospital services and of the resources required to meet those needs¹⁷;
- (d) support incentives to drive quality, efficiency and parity across public hospitals; and
- (e) provide relevant and timely information for monitoring against planned performance, and evaluating the role of resource allocation in driving and incentivising organisational goals.

FUNDING SOURCES OF HA¹⁸

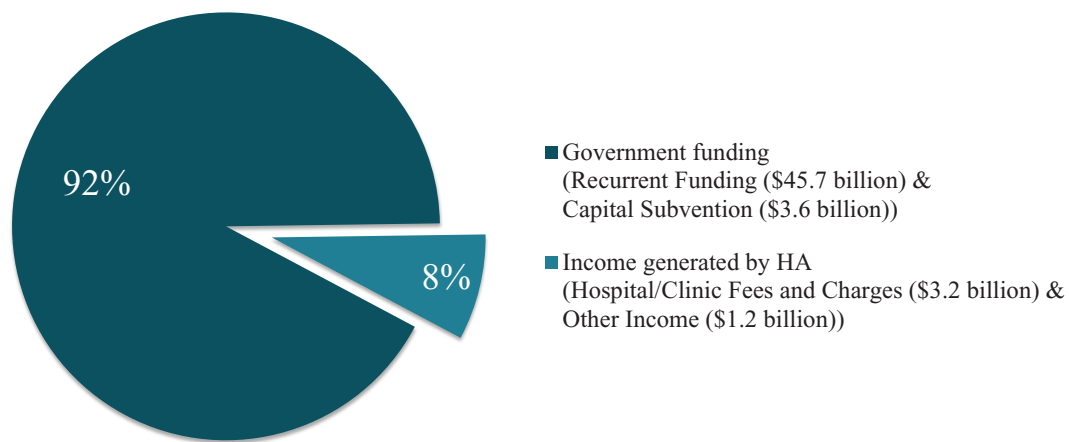
5.8 In 2013-14, the total available resources to HA amounted to \$53.7 billion, which came from two major sources, namely the Government funding and the income generated by HA as depicted below –

hospital services of the highest possible standard within the resources obtainable;” (HA Ordinance, Cap 113, Section 4 (c) (i)).

¹⁶ HA is under a statutory duty to “attract, motivate and retain qualified staff;” (HA Ordinance, Cap 113, Section 4 (c) (iv)).

¹⁷ HA Ordinance, Cap 113, Section 4 (b).

¹⁸ As financial results for 2014-15 are not yet finalised at the time when this report is under preparation, all financial information provided in paragraphs 5.8 to 5.17 are based on the 2013-14 fiscal year.



(a) Government Funding

5.9 The Government funding comprises recurrent funding and capital subvention.

5.10 Recurrent funding to HA is provided primarily to meet its day-to-day operational needs. In 2013-14, the Government’s recurrent subvention to HA was \$45.7 billion.

5.11 Capital subvention to HA is provided mainly in the form of block votes for infrastructure and initial set up, acquisition of equipment, introduction of information technology/systems, and implementation of facility maintenance and improvement work projects, etc. These votes include the Equipment Block Vote, the Information Systems Block Vote, the Capital Works Reserve Fund – Works, Furniture & Equipment and Improvement Works. In 2013-14, the total capital subvention amounted to approximately \$3.6 billion, with breakdown as follows –

| <u>Capital Subvention</u> | <u>2013-14 Actual</u> |
|--|-----------------------|
| Equipment Block Vote | \$0.4 billion |
| Information Systems Block Vote | \$0.2 billion |
| Capital Works Reserve Fund – Works, Furniture & Equipment | \$2.3 billion |
| Capital Works Reserve Fund – Improvement Works | \$0.7 billion |

(b) Income Generated by HA

5.12 In addition to Government funding, HA also generates its own income which comprises hospital/clinic fees and charges and other income.

Hospital/Clinic Fees and Charges

5.13 In 2013-14, HA reported a total of \$3.2 billion¹⁹ in hospital/clinic fees and charges, including income from drugs self-financed by patients and medical fee income.

5.14 Medical fees of HA are determined and published in the Gazette according to the HA Ordinance (Cap 113) under two categories, namely public charges and private charges. Public charges, which are in general set on an all-inclusive basis²⁰, cover both Eligible Persons and Non-eligible Persons²¹. All Eligible Persons utilising HA's public services are charged at highly subsidised rates without any means testing required. The fees have not been revised for 12 years (not even to take into account the impact of price inflation), the overall subsidy rates have since increased from a range of 77% - 100% to 84% - 100% today. Medical fees for Eligible Persons were last revised in April 2003. Non-eligible Persons are charged on a cost-recovery basis. Medical fees for Non-eligible Persons, together with private charges, were last revised in April 2013. In contrast with the all-inclusive public charges, private services are charged on a maintenance fee and itemised charge basis, where the charges are set on the higher of cost or market price for respective services. HA is also responsible for providing medical services to civil servants and their eligible dependants either free of charge or at concessionary rates.

5.15 To dovetail with Government's healthcare policy that no person should be prevented, through lack of means, from obtaining adequate medical treatment, patients who are recipients of Comprehensive Social Security Assistance (CSSA) are eligible to receive full waiver of public medical charges. Other patients with financial difficulties in paying the public medical charges can

¹⁹ Net of waivers.

²⁰ A flat rate is charged to cover, in general, medical consultation, drugs other than self-financed items, operation, procedures and investigations, etc.

²¹ Patients falling into the following categories are eligible for the highly subsidised rates applicable to "Eligible Persons" –

- (i) holders of Hong Kong Identity Card issued under the Registration of Persons Ordinance (Chapter 177), except those who obtained their Hong Kong Identity Card by virtue of a previous permission to land or remain in Hong Kong granted to them and such permission has expired or ceased to be valid;
- (ii) children who are Hong Kong residents and under 11 years of age; or
- (iii) other persons approved by Chief Executive/HA.

Other patients are subject to the rates applicable to "Non-Eligible Persons".

also apply for non-CSSA waivers (Medical Social Worker Waivers)²². In 2013-14, the total waiver amount in HA was about \$527 million.

Other Income

5.16 HA's other income, consisting mainly of non-medical fee income such as interest income and donation, amounted to \$1.2 billion in 2013-14.

RESOURCE UTILISATION IN HA

5.17 Healthcare is a labour-intensive service industry and about 69% of HA's expenditure (2013-14)²³ was spent on staff cost. Technology advancement is another driving force for health expenditure, for example, drugs, medical supplies and equipment together accounted for more than 14% of HA's total expenditure in 2013-14. Indeed, they grew at an average rate of 8% in the past 16 years, which is much higher than economic growth or HA's funding growth.

Evolution of Internal Resource Allocation Model within HA

5.18 In the Review, the SC noted that the internal resource allocation model of HA has evolved over time having regard to the social, economic and healthcare service environment at the time.

(a) Hospital Plan-Based Resource Allocation Model (Prior to 2001-02)

5.19 Prior to the establishment of HA in 1990, funds to individual hospitals were largely allocated on historical basis, focusing primarily on the resource needs of respective hospitals (input-based).

5.20 Following the inception of HA, a corporate strategy of developing output/outcome-focused care was established with a view to developing a resource allocation model that would progressively move from an input-based towards an output/outcome-based approach by linking resource consumption to output performance and/or outcome. Recognising resource allocation was an integral part of the organisation's business planning process, HA entered the era of Hospital Plan-Based Resource Allocation. Under this arrangement, hospital service agreements were formulated to specify the scope and level of services to

²² Waivers issued by Medical Social Workers of HA / Social Welfare Department, or Social Workers of Integrated Family Service Centres / Family & Child Protective Services Units of the Social Welfare Department.

²³ HA's total operating expenditure for 2013-14 amounted to \$49.6 billion.

be provided (i.e. the annual service plan of hospitals) and resources were allocated to respective hospitals according to the service level at agreed level of prices.

5.21 Three key features were developed to complement each other to facilitate the implementation of this model in driving efficiency: (i) Specialty Costing; (ii) Patient Related Groups; and (iii) Productivity Gain.

5.22 Specialty Costing measures the average cost of HA services for treating a patient within a clinical specialty. It was developed as an interim tool to provide a common unit of cost measurement for allocating resources according to agreed service levels. The concept of Specialty Costing was first applied in 1992-93 for allocating additional drug expenditure, and its use was subsequently extended to allocate up to 40% of the 11 acute hospitals' resources by the late 1990s. To link resource input with output/outcome, HA pioneered the development of a locally customised patient classification system, the Patient Related Groups. The Patient Related Groups complemented the Specialty Costing in accounting for variations in the mix of cases and the level of care among hospitals.

5.23 A mechanism of productivity gain was also introduced, where "productivity savings" from hospitals were pooled for further redistribution to encourage hospitals to optimise efficiency and to provide hospitals with funding source for new and improved services. This mechanism was first applied in 1993 at 1% of HA funding and subsequently increased to as high as 3% of the funding, amounting to a total of \$2.1 billion savings over the six years period from 1993-94 to 1998-99.

Limitations

5.24 While the use of Specialty Costing and the Patient Related Groups information in allocating resources under this output/outcome-based model had helped reduce variation in unit cost among major acute hospitals, and the concept of productivity gain had facilitated steady growth in the share of ambulatory and extended care services to better meet the needs of the community, this model had a perceived drawback of favouring hospitals experiencing volume growth. This gave rise to the unintended consequential effect of encouraging hospitals to vie for volume growth. In 1998-99, HA refined the model so that "productivity savings" were no longer pooled for redistribution and the hospitals concerned could keep their savings for service improvement. The role of Specialty Costing and the Patient Related Groups information had also been altered to serve as references for subsequent resource allocation.

5.25 Another shortfall of the model was its fragmented approach of service planning and resource allocation based primarily on individual hospital's service plan. With its limited regard to the overall picture of the society's service need and the low level of central coordination, this model had not been conducive to HA's efforts in directing its resources to meet the population's greatest need. Its unintended effect on encouraging volume growth also offered little incentive for hospitals to achieve better efficiency and effectiveness in resource utilisation.

(b) Population-Based Resource Allocation Model (2001-02 to 2008-09)

5.26 In the late 1990s, HA began to formulate rationalisation and integration plans to move its medical services from an inpatient setting towards the ambulatory and community mode with a view to achieving better productivity. This change in service delivery mode implied a need to review the then internal resource allocation model adopted by HA.

5.27 Against this background, HA commenced the development of its population-based internal resource allocation model in early 2000's. The objectives of this new model were –

- (a) To provide resources based on the needs of the community served – equality in resources for equal needs (equity principle); and
- (b) To provide incentives to hospitals for improving the organisation and delivery of services within the hospital clustering environment.

5.28 Under this model, resources were allocated to each cluster according to the headcount and age profile of the population of the catchment districts (demarcated based on the location of hospitals within that cluster's administration), and adjustments were made to take into account the cross-cluster flow of patients. Clusters/hospitals were responsible for assuring that service needs were met either within their own cluster or from other clusters. They were given the flexibility to rationalise their services provision/mix to meet the needs of their local population. They were also encouraged to improve both internal service coordination between clusters and external collaboration with primary care/private sector providers, as well as to pursue technical efficiency.

5.29 The introduction of this population-based resource allocation model in 2001-02 coincided with the Government's Enhanced Productivity Programme implemented across the public sector to achieve the best value-for-money in Government expenditure while maintaining and improving the quality of public services. As a result of this programme drive and other efficiency savings

measures implemented up to 2005-06, HA delivered a total of around \$3.5 billion savings during the six-year period from 2000-01 to 2005-06. This might have somehow posed some challenges to the implementation of the population-based resource allocation model in HA in the relevant years. Notwithstanding the Enhanced Productivity Programme drive and efficiency savings measures, the Government continued to provide additional recurrent funding of about \$2.3 billion (on top of the annual recurrent subvention) to HA to cope with the population growth and service needs during the same period.

(c) Refined Model under the Pay-for-Performance Concept (2009-10 to 2012-13)

5.30 To drive further improvement in its resource management, both in terms of the baseline resources of clusters and their additional new funding received each year, HA refined its resource allocation model by adopting the concept of Pay-for-Performance in 2009. This refinement aimed to modernise patient care processes through directing more focus on quality and outcome, and to better link resource utilisation with output/outcome. At the same time, the model strived to further promote productivity while ensuring resources are deployed to targeted areas of need through a transparent mechanism.

5.31 Recognising the need for a tool to promote clusters' productivity, a baseline budget redistribution mechanism was built to measure efficiency among clusters. This mechanism involved the application of a modest efficiency adjustment to clusters' baseline resources based on their acute inpatient throughput measured using Casemix²⁴. A cluster's actual cost in producing a certain level of throughput was compared against HA's average cost expected to produce the same level of throughput, with the difference being the efficiency variance. Clusters with higher than expected costs would be asked to improve their efficiency by reducing their baseline resources and/or increasing their throughput. Resources would be redistributed from the "over-funded" clusters to the "under-funded" ones according to casemix-adjusted costs.

5.32 To ensure that additional new funding was directed towards priority areas under the Pay-for-Performance concept, new resources were deployed to clusters across three strategic performance areas –

²⁴ The Casemix model adapted by HA is built upon an internationally-adopted patient classification system, namely the Diagnosis Related Groups system. Through classifying acute inpatient admissions into the Diagnosis Related Groups, hospitals' workload can be measured, and compared against each other, by the number of cases they treat and adjusted by their complexity.

- (a) Service growth in areas of greatest need such as high demand pressure areas and expansion of treatment for life threatening conditions;
- (b) Improvement in patient safety and quality; and
- (c) Initiatives that enhance services through training and retention of staff, and adoption of advanced technologies and treatment.

5.33 As another key focus under the Pay-for-Performance concept, improvement in quality was also emphasised with the introduction of a three-year Quality Incentive Pilot Programme. Through consultation with relevant clinical groups, strategic priority areas were identified and a set of quality performance indicators were developed for measurement. In recognising clusters' performance in quality improvement, financial incentives were rewarded to clusters for either achieving the pre-set targets, or for demonstrating improvement for each indicator.

5.34 Following the principle of “same service, same price” under this Pay-for-Performance concept, unit costs of respective clinical services formed the basis for allocating new resources to strategic areas of service needs. In formulating this “purchasing unit price”, Specialty Costing as well as casemix information (for acute inpatient services) had been used to measure and reflect the resource requirements of the hospitals.

Strengths

5.35 The use of Casemix information under this model gave due considerations of complexity in the inpatient services provided by clusters and it had been a significant step for HA in refining its resource allocation. Such information had also facilitated public and stakeholders' understanding of HA resource requirements.

5.36 The establishment of the baseline budget redistribution mechanism as an efficiency measurement had also successfully raised clusters' awareness of and incentives to drive efficiency improvement.

5.37 The strategic drive of resources towards targeted performance areas had enabled HA to systematically optimise and broaden the use of its resources over a multi-dimensional focus that not only met the growing demand from rising and ageing population, but also addressed resource needs to facilitate improvements in technology, quality and safety as well as the workforce.

Limitations

5.38 Despite the benefits this model could offer, it had the following underlying deficiencies that had undermined its effectiveness -

- (a) Clusters' perception of inequality of the baseline budget redistribution mechanism due to its confined focus on acute inpatient service alone;
- (b) The approach of redistributing baseline resources at the cluster level had not been effective in facilitating the identification of specific areas at hospital level or services with efficiency issue requiring management attention;
- (c) Driving for activity growth given the prevailing market shortage in healthcare professional had further exacerbated the workload of HA; and
- (d) Focusing primarily on resource need and service throughput was not conducive to delivering outcome-focused medical care.

5.39 In light of the above observations, both the baseline budget redistribution mechanism as well as the purchasing arrangement for new services (i.e. at respective "unit price") had been put aside since 2012-13 to avoid further drive for unnecessary activity growth given the manpower shortage. In the same year, the Quality Incentive Pilot Programme had completed its three-year trial period and its scope had been well incorporated by the emerging and ongoing development of other quality initiatives.

(d) Current Framework (from 2012-13)

5.40 At present, HA's service planning determines how resources are allocated across the organisation. This is further reinforced through the structured service planning framework to ensure the best use of public resources in the delivery of quality care services.

(i) Resource Allocation to Cluster

5.41 In 2012, HA published its latest Strategic Plan 2012 – 2017 to set out its strategies and priorities for the next five years. The development of this document was led by the HA Board and involved extensive consultation and discussion with both internal and external stakeholders. Through extensive

environmental scanning of HA's internal and external context, key outstanding issues and gaps across different aspects of the organisation, such as service needs, patients' expectation, medical technology and facilities requirement, etc., were identified. Noting that many of the gaps revealed could only be addressed over a period of time in a progressive manner, HA drew up medium term strategies and directions accordingly with a view to aligning and balancing these service/quality gaps across respective clusters while addressing the relevant challenges of maintaining an adequate workforce, managing growing service demand, ensuring service quality and safety, and enhancing corporate governance. These medium term priorities would be implemented and monitored through appropriately redistributing existing or allocating additional resources to targeted areas of need during the Annual Planning process.

5.42 The Annual Planning process itself is a participative exercise with bottom-up and top-down contributions throughout the organisation. Views are collected from frontline clinical staff and cluster management to HAHO executives. Every year, resource requirements for new services and specific pressure areas are deliberated at the Annual Planning fora with inputs from stakeholders across all clusters.

5.43 Through the above Annual Planning process, HA formulates its Annual Plan, incorporating all new programmes that are approved for implementation for the year, including territory-wide and specialty-based programmes, as well as cluster/hospital/department-specific initiatives, with set targets to be achieved and reported.

5.44 Upon the Government's notification of its total recurrent funding to HA for the year, resource allocation to clusters (including manpower, equipment, facilities and other operating needs) will be determined based on the following considerations –

- (a) the resources needed to sustain the baseline operations of respective clusters, including their core primary and secondary services as well as any centralised services under their management;
- (b) additional resources required to deliver the new services that have been supported during the annual service planning process; and
- (c) any other resources needed to address specific pressure areas/gaps.

(ii) Resource allocation within clusters

5.45 Charged with the responsibility to ensure operational efficiency while delivering the targets set under the Annual Plan, respective cluster management will likewise work out its cluster's service plan according to the baseline need, new services supported and pressure areas of its hospitals/departments, and make necessary service reorganisation and rationalisation to ensure that there is optimal deployment of resources to targeted areas of need. To ensure transparency in resource allocation, relevant stakeholders are engaged throughout each cluster's resource allocation process to prioritise new initiatives from hospitals within the cluster and agree on a service plan, based on which the clusters will prepare a viable budget plan to balance the financial requirements with the resources available.

5.46 In parallel with the evolution of different internal resource allocation model as detailed above, the Government's subvention has been increasing over the years. In the ten years from 2006-07 to 2015-16, the Government's recurrent subvention to HA has increased from \$27 billion to about \$49 billion, representing an increase of nearly 80% or about \$22 billion. It is high time for HA to ensure a better and more efficient allocation of this increased baseline provision.

EVALUATION ON RESOURCE MANAGEMENT

Resource Allocation Model

Views from the Public Engagement Programme

5.47 Resource management is understandably a contentious issue. Various parties, including HA's cluster management and frontline staff as well as stakeholders outside HA, have expressed their views on the subject when meeting with the SC.

5.48 In summary, the SC received quite a significant number of views expressing concerns on the existing resource allocation model and showed support for a population-based approach. The general perception was that the present resource allocation model was unfair as the resources 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 for the year 2013-14. There were also criticisms that the present model often focused only on new money for implementing new services, leaving the inherent “unfairness” in baseline provision among clusters unaddressed. Many expressed comments that a population-based model would provide a fair and transparent mechanism in allocating resources. It would allow resources to match the prevailing service needs rather than historical provision.

5.49 However, the SC also noted that there were concerns about a resource allocation model solely based on population size. Specifically, there were worries 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 teaching duties on top of service provision). For example, the Queen Mary Hospital provided liver transplant services for patients throughout the territory. It also served as a teaching hospital 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. The Hong Kong Eye Hospital at KCC, as another example, served a large number of patients from other clusters. 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.

SC’s Considerations

5.50 Members of the SC appreciate the limitations of the existing resource allocation model in which the resources allocated for certain clusters do not appear to be commensurate with the corresponding population. Recognising that population is a key factor in generating workload and thus resources requirement for a cluster/hospital, the SC agrees that the concept (with sufficient refinement – see below) of a population-based model should be most able to address the public concern and perception of equality, equity and transparency.

5.51 However, members of the SC hasten to point out the risk of going to the extreme of allocating resources through simplistic arithmetic by following one and only one single factor, namely population. Taking such a simplistic model will disregard the centralised and/or tertiary and quaternary services provided in certain clusters as well as the demand generated in the cross-cluster services. In particular, service demand in a cluster where A&E services are provided is to a

certain extent determined by the proximity of the cluster with the location of the incident, there are bound to be cases where patients are sent to clusters outside their residential area to receive A&E and consequential services (hospital admission via A&E and related outpatient services). The SC considers that a refined population-based model should take due account of the resource requirements of clusters and hospitals concerned for undertaking centralised and/or tertiary and quaternary services and providing services to patients residing in other clusters.

5.52 **Recommendation 3: the SC recommends that –**

- (a) HA should adopt a refined population-based resource allocation model by reviewing the present approach and taking into consideration the demographics of the local and territory-wide population. The refined population-based model should take into account the organisation of the provision and development of tertiary and quaternary services, and hence the additional resources required by selected hospitals or clusters, as well as the demand generated from cross-cluster movement of patients; and
- (b) HA should develop the refined population-based resource allocation model and implement through its service planning and budget allocation process within a reasonable timeframe. To avoid unintentional and undesirable impact on the existing baseline services of individual clusters, HA should consider appropriate ways to address the funding need of clusters identified with additional resources requirement under the new model, while maintaining the baseline funding to other clusters.

Procedures in Resource Allocation

Views from the Public Engagement Programme

5.53 During the Public Engagement Programme, some HA staff raised concerns on the tedious and complicated procedures involved for bidding new resources. Some were particularly uneasy with the requirement to obtain clearance from various committees and hierarchies at hospital, cluster and HAHO level 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 relevant COCs to ensure consistency and coherence in service provision at the corporate level.

5.54 Some staff were also concerned that the decision-making process of the internal 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 enjoy greater advantages 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.

SC's Considerations

5.55 Members of the SC note the general sentiments of frontline staff on the process of resource allocation. While managing an annual funding of some \$50 billion for an organisation comprising 42 hospitals/institutions with some 70,000 staff is a mammoth exercise and certain degree of flexibility is inevitable in order to meet local operational needs at the cluster/hospital level, there is room to improve the logistics and enhance transparency in the process to alleviate staff's concerns.

5.56 **Recommendation 4:** the SC recommends that –

- (a) HA should work to improve and simplify the procedures of bidding new resources by clusters for new or improved services at the next resource allocation exercise (in 2016-17), with a view to streamlining and expediting the process and minimising the administrative workload of frontline clinical staff, balancing the need for efficiency and accountability; and
- (b) HA should enhance transparency of the resource bidding and allocation processes through better internal communication with clusters and within clusters on the methodologies, priorities and selection criteria. For the same reason, HA should explain the rationale and considerations behind the final decisions and allocation result starting with the next resource allocation exercise (in 2016-17) so that clusters can have a better understanding of how priorities are being determined and how resources are being allocated within the whole organisation.