



Keynote Address by Mr Shane Solomon
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The Hospital Authority – The Way Forward

Introduction

Mr Li Xi, Dr York Chow, Mr Anthony Wu, honorable guests, distinguished speakers, colleagues, ladies and gentlemen. Good morning, and welcome to the HA Convention 2006.

Immediately after arriving in Hong Kong, I visited a number of hospital staff and other stakeholders to understand their concerns. There is no doubt that Hospital Authority has many great achievements over the past 15 years. But like other health systems throughout the world, we are also facing many challenges, so change is inevitable. Today I want to outline the key elements for the way forward for HA over the next three years.

Outline

I see three key parts of the way forward for HA.

First, HA must keep modernizing itself, in line with fast moving developments in health care. Second, HA must work to reduce avoidable hospital use if it is to deal with the future demands of the ageing population and with chronic health conditions. Third, HA should promote a wider range of choices for patients.

Finally, I will discuss a couple of critical success factors which are pre-conditions for achieving these key directions. Internally, HA's culture needs re-energising around its core organizational values. Externally, financing reform is necessary for HA to sustain its world class health system.

In discussing the way forward and the critical success factors, I will reflect on what I have observed in the short time I have been at HA, and the many pieces of welcome advice I have received.

Direction 1: Modernizing HA

Health care is like a fast moving river. The international research industry that surrounds health care guarantees change.

Hong Kong should be proud of its modern hospital system that has been the result of years of hard work by many committed professionals. Before I was able to take a look myself, I was not sure what I expected to see in Hong Kong hospitals, but I was sure it would be different. One of my initial surprises was how much was familiar – all the elements of a

modern hospital system are here – highly trained professionals, strong research emphasis, state-of-the-art surgical facilities, quality auditing, highly computerized medical records, automated pathology, digitized radiology, and so on.

But HA must keep modernizing and innovating. Of course, we must keep pace with new treatment methods and new technologies, but I want to suggest some other areas of modernization which I think are also important.

First, staff roles can be further modernized, around the concept of “right function, right skill”. On the one hand, this involves taking more mundane tasks away from highly trained professionals, such as our scarce doctor and nurse resources doing administrative tasks. On the other hand, possibilities for extending the scope of practice for nurses into more specialized areas need to be explored, consistent with practices in other parts of the world.

Second, facilities need to be modernized to reflect modern clinical practice, improve the patient experience, and reduce the potential for cross-infection. Investment in new, upgraded, or replacement facilities needs to be placed within a well considered Health Services Plan for Hong Kong which considers among other factors, the population distribution, future demand projections, and consolidation and rationalization of services to achieve a critical mass.

Third, modern management systems need to be embraced by HA. These aim to make the complexity of health care more simple, and so more manageable. The suite of management systems which HA should embrace include:

- staff workload systems that match patient activity with staff resources,
- staff performance management training,
- enterprise resource planning systems (ERP),
- use of benchmarking across HA,
- clinical audit.

These modern management techniques can point to areas where change is needed to make best use of public resources. But these tools are only useful in the hands of skilled managers. The most important skill is in change management which has as its foundation a willingness to negotiate with affected people. These most widespread change in HA is likely to be freeing up employment practices, such as, flexible shift patterns, more part-time work opportunities, and a willingness to move staff around a hospital (and between hospitals) in response to changes in demand pressures.

Fourth, information technology has been the key to modernizing many industries, and health is no exception. The Clinical Management System (CMS) in HA would be the envy of the rest of the world, if it was better known – certainly any part of my old health system in Australia can only aspire to have such a system one day. It presents an excellent platform for further reform of clinical processes. CMS should take the next step into decision-support of the clinicians, through in-built prompts and warnings to support clinical risk management. It should be used more extensively to automate clinical processes. The system needs to step outside the walls of HA, and into the private sector, and preferably into the hands of the patients so that individuals are able to manage their own health better. These are exciting opportunities, and I am confident that the pioneering spirit that created HA’s clinical information system will take it into this new generation.

Direction 2: Reducing avoidable hospitalization

We are all aware of the pressures of an ageing population and the growth in people with chronic conditions. The tone can sometimes borders on resignation and helplessness. But there is much that can be done about this wave that has already reached us and HA should embrace the challenge. The key is to refocus our efforts towards reducing avoidable

hospitalization – or to put it another way “the future of hospitals is outside of hospital”. Not only will this reduce future pressure on HA hospitals, but it reflects patient preferences to remain at home if possible.

International evidence shows very large variations in hospitalization rates, and how long people stay in hospital, so we know there is much scope to reduce demand pressures on hospitals.

The Health and Medical Development Advisory Committee report ‘Building a Healthy Tomorrow’ emphasized this direction through its call to build up the family physician system.

Much of the reduction in hospital length of stay has been achieved by new technologies, such as minimally invasive surgery and improved anaesthetic technique, but offering alternative services in the community or in step-down facilities has played a big part.

I commend HA’s significant achievements in reducing length of stay: patients having cholecystectomy now on average stay for 5.5 days, 21% less compared to 5 years ago. Similarly, patients having cataract surgery performed as day case has increased by 13%. But there is still room to look further to reduce demand on hospital beds. For example, only about 60% of cataract operations are performed as day cases in HA, compared to 90% in UK and Australia. Cataract operations is one example only, and we should look across HA for further opportunities to increase day surgery and bring length of hospital stay in line with international standards.

In mental health services, HA has reduced psychiatric beds by 10% over the last 5 years, and still managed to treat 15% extra inpatients. Such a reduction was only possible through building up of community mental health services. There is still scope for more movement towards caring for people in the community. The number of psychiatric beds per 1,000 population is 0.66 in HK compared to 0.21 in Victoria and 0.58 in UK. To change this will take up-front investment in providing alternative community mental health service support and new accommodation options.

Community services for the elderly are a key part of reducing avoidable hospitalization. More than 40% of hospital admissions, 65% of unplanned readmissions, and 50% of bed days in HA are utilized by elderly patients. HA has made progress and I have seen many positive developments. The establishment of Community Geriatric Assessment Teams (CGATs) and Visiting Medical Officers (VMOs) scheme have reduced Accident and Emergency attendances and hospital admissions from aged care institutions by some 15%.

A strong primary care system is essential to reduce hospital use by the elderly. This must include not only affordable primary medical care, but also community nursing for people at home, basic home support services (such as meals), and access to pharmaceuticals in the community.

Sub-acute services in the home and transitional accommodation for the elderly provide better alternatives for some than long stays in an acute hospital. Of most interest are the tailored programs for those with chronic conditions at high risk of hospitalization. In Victoria, we created a program called the Hospital Admission Risk Program (HARP) to pilot new models of care in the community. The program succeeded in reducing hospitalization rates amongst high users (more than two inpatient admissions per annum) by 30% to 40%, along with similar reductions in Accident & Emergency attendances and length of stay.

I am learning that Traditional Chinese Medicine is likely to have a stronger role in reducing hospitalisation through its emphasis on prevention and health restoration. HA’s strategy of progressive implementation of TCM in partnership with the private sector will establish the evidence-base and collaborative model to further respond to community demand for TCM.

These sorts of hospital demand prevention services need a lot of building up to have a serious impact on the use of hospitals and are an essential part of a sustainable Hospital Authority in the long term. They will require up-front investment before an impact on reducing demand is achieved.

Direction 3: Patient choice and access

Health systems should reflect the nature and aspirations of the community they live in. So it is surprising to me that a diverse, cosmopolitan, commercial centre like Hong Kong has such a limited range of health care choices for its citizens.

More choices of hospital and health care are needed. Perhaps these will emerge in the private hospital market. I hope so, and HA should welcome expansion of the private sector because it will both relieve demand on HA and shorten waiting times for discretionary areas, like elective surgery.

HA itself has a role to play in expanding choices and it is clear that HA has many patients already with the capacity and willingness to pay for these additional services choices. HA data shows that among users of HA hospitals, 23% have medical insurance or subsidy, compared with 37% in the total Hong Kong population. The top 10% of HA users have monthly incomes over \$35,000 per month – that is about 200,000 of our existing patients earn more than double the median income for all of Hong Kong.

So HA is already attracting a significant portion of people who have chosen to spend extra on their health care or have the capacity to do so. I'm sure that they choose HA rather than private hospitals for many reasons: the service they need is of such a specialized nature that it is only available in the public sector (eg. Liver transplant); they prefer the on-site back-up diagnostic or emergency services at HA hospitals; they may be treated by a prestigious university professor; or perhaps they cannot afford to pay the full cost of private care. The reasons will vary and will continue to be legitimate, so it is simplistic (and I would argue undesirable) to position HA as only for those who have low incomes.

If more people can choose to contribute to the cost of their own care in public hospital, then HA's own scarce resources can be directed to lower income patients who are waiting long periods of time for elective surgery and only have the choice of HA.

More work needs to be done on what extra choices should be offered in HA – here I am only stating a direction or principle. In debating the possibilities for patients in HA, we will need to be mindful of the wider community impacts (particularly to ensure the private hospital system continues to expand) and have adequate community debate. The focus should remain on expanding choice for HA's existing patients through both the private and public hospital systems.

Critical Success Factors (CSF)

I have said that there are three key directions HA should be pursuing: continuing to modernize HA; reducing avoidable hospitalization; and improving patient access through more choice.

I believe these directions will rely on two critical success factors. One concerns the internal HA culture, and the other is external financing reform.

CSF: HA Culture and Values

On the HA culture first. I only have time to touch on one dimension of culture today, and that is HA's core values. I want to talk briefly about the core values that are important to me, and some behaviours that should follow from these core values.

It is clear to me that HA has a core value of hard work and loyalty. The SARS response was outstanding – all staff stayed at the bedside despite the obvious danger to yourselves. The epidemic was brought under control in a very short time. This could not have been achieved without a high level of professionalism and commitment.

I have heard of a lot of staff dissatisfaction at the time also, and I suspect this comes from a feeling that staff efforts were not being adequately recognized, and a perceived lack of fairness across HA.

I have heard much about staff morale. Most often this is mentioned by nurses talking about excessive workloads, doctors working long hours, staff having to deal with unreasonable complaints from patients, and a lack of hope about career progression (as a doctor said to me recently “is there light at the end of the tunnel?”). These challenges will take a collective effort across HA, and will not be fixed overnight and some degree of resistance can be expected.

So while there is a clear HA core value of hard work, front-line staff are looking for their work to be valued and recognized and to be treated fairly by management.

The core values I want to promote in HA to improve staff morale and service to the community are: respect, fairness, teamwork, professionalism, and innovation.

Core Value: Respect

I like to put ‘Respect’ first. I interpret the HA core value statement ‘Quality patient centered care through teamwork’ as essentially meaning respect to patients and respect to your team members. All staff should respect the contribution that each part of the HA team has to make. Respect is the foundation of teamwork which is what makes organizations succeed or fail.

Respectful behaviours include sound staff-management practices, for example, contract renewal occurs in a timely manner. Respect seeks the views of all key members of the team involved in multi-disciplinary care, including doctors, nurses, allied health, and supporting staff. Respect involves consulting people, but there are times when it also involves being willing to make a decision out of respect for the whole team.

Core Value: Fairness

Fairness is best understood by its opposite: favoritism. All HA staff should be treated fairly, and this should be clear to all in a workplace.

The value extends to how resources are allocated across clusters and within clusters. This should be fair and transparent. Many in the open staff forums have expressed concern about the HA financing model. Will I continue with the population based funding model, I have been asked at many forums?

There are two aspects of fairness to consider in designing the future funding distribution model. There is fairness to a community – there should be a fair distribution of resources across Hong Kong communities. But there is also fairness to the staff delivering the services – resources should be allocated in a way that allows staff workloads to be similar across like services.

A population based funding model deals with the first fairness (fairness to a particular community or population), but not necessarily with the fairness in the distribution of staff workloads. The funding model must seek a fair distribution of resources across Hong Kong, but also spread the staff workload fairly, and funding models based on services delivered are

better able to deal with unfairness in staff workload. Funding models that distribute on the basis of staff workload typically allocate funds on the basis of a program or casemix or level of service activity. My preference is to use some type of activity and program based funding as the core method of funding distribution, but use a population planning approach to allocate (or reallocate) resources to populations with relatively low levels of service. This can achieve fairness for the staff doing the work, and fairness across communities.

Another dimension of fairness relates to staff conditions and benefits. The term “unequal pay, equal work” has been quoted to me often. I accept this is an issue, and a way forward needs to be found to address this unfairness.

I think there is also the opposite present in HA: “equal pay, unequal work”. There is a large variation in workload in the medical grade, both among different specialties and within the same specialty but among different hospitals. The number of hours can differ by 100%, as can the on-call frequency. I have been told that nurse workloads are heavy and have been given some data to suggest workloads vary significantly across HA.

Although I have been here for a very short time, I believe at the heart of the staff morale issue is a sense that staff should be treated fairly, that the workload is not evenly distributed, and that employment terms are not fair across staff, and that HA lacks a strategy to change the current situation.

In addition to the initiatives taken this year to re-introduce increments for staff employed after 2002, I intend to review three key areas in the next 6 months to find a fairer approach to workload and career progression:

- Data on nurse workloads across HA will be collated to identify the unreasonable workloads and the action that needs to be taken as a matter of priority to redress the problems.
- An expert review panel will be formed to map out a strategy for the future restructuring of doctors’ workload within HA, including distribution of levels of doctors’ workload, career progression, on-call systems, and contract structure.
- The nature of employment contracts varies across HA. The implicit human resources policy that has emerged in HA is short-term contracts. The employment relationship between HA and front-line staff needs changing to balance the following principles: providing staff with more employment certainty; staff motivation through rewarding good performance; flexibility for management to alter the mix and level of staff as demand and resources change; fairness across staff in HA employed at different times; and finally (and most importantly) treating good performing staff as valued colleagues who HA wants to retain. The current short-term contracts, despite increasingly long years of good service, do not provide staff with sufficient certainty to encourage retention. A new model will be developed as HA’s policy for future employment relationship – there is a big gap between the 10,000 HA staff on 3 year contracts and permanent employment.

While it is likely to take some time to achieve the changes, at least these reviews will provide us with a blueprint, and hopefully give staff some confidence that HA at least has a plan for change.

This is following down the path of the core value of fairness and if action can be taken, I hope will restore some trust between management and staff and improve staff morale.

Core Value: Teamwork

Teamwork is a value that features strongly in HA. One of the words I hear often here, which was not common in my culture, is the term “colleagues”. This is both a word of respect and teamwork. Mostly I see a strong sense of team across HA, but great organizations keep reinforcing and working on being a team.

Teams do not emerge naturally, they are built by people stepping forward to be leaders and others willing to adapt their individual desires to the needs of the whole team. Leadership stimulates teamwork and builds trust. It takes courage to be a leader, because it involves taking tough decisions, and criticism is a constant risk. We need to value leadership throughout the organization, extending to Chiefs of Service (COSs), Department Operations Managers (DOMs) and beyond.

A leader is totally dependent on his or her team and so must value and support other members of the team.

Some team behaviors that are particularly important are: listening, asking questions, building consensus, recognizing what others have achieved, saying thanks, celebrating success, being sensitive to others in the team when they are going through a difficult time, and many others which I'm sure you will recognize yourselves. I have already observed these team-building behaviours extensively across HA, so there is much already to build on.

Core Value: Professional Service

The final value relates most directly to our mission of service. Professionalism is about a state of mind that we will not settle for ordinary service, but will strive to a higher level.

Professionalism relies on the support of sound teaching and research, which constantly drive forward the quality of HA, and I can see that HA is very well served by academic institutions. The passion for excellence comes from those who are academically rigorous and willing to test claims and counter claims, a belief that services should be based on evidence.

Professional services involve continuing to be committed to patient care, even when you have to spend much time and effort to do so and even when your efforts may not be readily recognized.

Core Value: Innovation

For HA to modernize and introduce new service models, clinical innovation needs to be fostered and treasured. It is natural to look up the organizational hierarchy for direction and decision. But HA is a big organization, and if it waits for myself or other senior managers to say what has to be done, then too little will be achieved.

What I am looking for is staff to come forward with good ideas – innovations, particularly clinical innovations – that can be debated, tested, and spread more broadly across HA. Good organizations have a mix of top- down direction and bottom-up innovation. I have already heard so many good ideas which I would like to see happen, and am determined to find ways of supporting clinical innovators to have their ideas implemented.

CSF: External Financing Reform

There is much expectation of financing reform in Hong Kong. At the end of this presentation, I would only talk about its importance and some broad principles.

Government funding increase to HA has been guaranteed for three years. HA's credibility rests on demonstrating that it makes good use of these resources. The directions I have mentioned earlier will help – modernising management practices and preventing avoidable

hospitalisation.

If HA wants to do more, such as further improvements to staff morale or reducing patient waiting times, then we should look increasingly to private revenue opportunities. The obstetrics NEP package has raised \$122 million in 2005/06.

Financing reform should provide the climate to increase the number of private hospital beds above the current 9%, and so divert some patients away from HA.

It will need to create the right incentives to encourage the public to use services sensibly and take some responsibility for their own health care. The incentive should be to reinforce the most appropriate service option, which is often at the lower end of the service continuum (for example, a primary care physician rather than an Accident & Emergency Department, a General Out-patient Clinic (GOPC) rather than a Specialist Out-patient Clinic (SOPC), or an aged care home rather than a hospital).

HA is concerned to ensure patients are not denied service because of lack of financial means, so we will naturally look for a safety net which caps people's out-of-pocket payments for HA services over an extended period, and this safety net needs to cover all income groups, particularly low and middle income HA users.

We should not be concerned about more HA patients using the private sector – whether private hospitals or private specialists or family physicians, and so actively support public-private collaboration initiatives. This not only reduces demand on HA, but also reflects patient choices. The end result is that HA's resources are freed up for use on those who only have the option of using public hospitals, particularly those with low incomes, and to deal with staff morale arising from high workloads.

Without compromising this positioning of HA, there is further potential for public-private partnerships which expand patient choices, such as in Traditional Chinese Medicine, and more attraction of NEP patients where there is spare hospital and staffing capacity.

Conclusion

I encourage you to participate constructively in the financing reform debate because it is a key part of HA's sustainability into the future. I am aware that such debate has occurred in Hong Kong many times in the past two decades, and there is some skepticism that anything will come of it this time. It will take time to work out the details and have community debate, but this opportunity must not be lost.

The success of financing reform will have a major impact on HA's capacity to modernize, reduce avoidable hospital demand, offer more patient choice, and put into action some fundamental values to improve staff morale. This will improve access to HA for the most vulnerable in the community, such as low income people, the elderly, and those with chronic conditions who rely on HA to continue participating independently in the community.

I am looking forward to the challenges ahead, and to working closely with the HA colleagues. Thank you.

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