Keynote Address by Mr Shane Solomon
Chief Executive, Hospital Authority
at the Hospital Authority Convention 2007
on 7 May 2007

2020 Two

Dr Ma, Dr Chow, Mr Wu, honourable guests, distinguished speakers, ladies and gentlemen. Good morning and welcome to the Hospital authority Convention 2007.

INTRODUCTION

At last year's HA Convention, I proposed that the way forward for HA is to keep modernising, reduce avoidable hospitalisation, and increase patient access and choices. The critical success factors for achieving these were changes to the HA culture and healthcare financing reform.

At the outset I want to express HA's appreciation to the Government, and particularly the Secretary for Health, Welfare and Food, for their support to HA. Operating funding has increased by 2.4% compared with 1% last year. HA has received $500 million to modernise its equipment, more than double that of previous years.

I would like to build further on last year's themes by inviting you to imagine HA in the year 2020, from the patient's perspective and the staff's perspective. With this in mind, I want to suggest five strategies for the next two years, which will take us along the path to HA 2020.

My message today is a simple one: to modernise HA and to reduce avoidable hospitalisation, patients must take responsibility for their own health, and we must help them and insist that they do. The key is giving our patients the choices, the skills, the support, the incentives, the information, and the means to manage themselves. The outcome will be a healthier community, and less dependence on HA.

HA 2020 — FROM THE PATIENT'S PERSPECTIVE

In 2020 our patients will mostly be elderly and have multiple chronic conditions, with respiratory illness, cardiovascular disease, cancer, and mental illness at the top of the list. We estimate that by 2020, we will be spending close to $20 billion on these four areas alone.

Patients will be better educated and have even higher expectations than now. They will expect more information on the outcomes of treatments being offered, and HA's performance on quality. As more evidence comes to light about mistakes in hospital and the risks of some interventions, patients will not just accept what we say about what is good for them.

Instead of going to different HA specialists to have their multiple chronic conditions treated, Hong Kong citizens will increasingly rely on the family doctor who knows them well and can help them manage their inter-related health issues. Even today 47% of HA patients over 65 years see more than one specialist in a year, with 19% attending three or more HA specialists over a year. As the patient population ages further, integrating the care delivered by multiple specialties will become more important.

Follow-up maintenance care will be delivered more by primary care practitioners than specialists. Currently 91% of our 5.8 million specialist outpatient attendances are for "follow-up" visits, and in other countries much of this is handled by a family doctor whose job is to provide integrated care of multiple conditions, episodic and chronic.

The family doctor will be supported by skilled nurses and allied health professionals in the one location, mixing public and private sector practitioners.

All HA patients with chronic diseases will participate in self-management programmes. These will give patients and their carers the information, skills, and confidence to do what is needed to keep them healthy and out of hospital, even after a stroke, cardiac failure, diabetes diagnosis or respiratory illness.

Patients will know what to expect from HA. The "core service offering" will be well known by HA citizens (of course, after much debate). It will include pledges on waiting times (even for "non-urgent" services) and include proven new technologies and treatments, and will be high quality and well founded in evidence.

There will be additional choices beyond the HA's "core service offering", but this will require patient co-payment. These "add-ons" may include more pleasant physical amenities, the chance to choose your own doctor (even in a public hospital), and quicker treatment for non-urgent services.

Patients will demand and receive much more information from HA and elsewhere than they do now so that they can make better choices and manage their own health. They will know that doctors are too busy to give them the information they need, so they will get information from many sources, particularly the internet (preferably through an authoritative HA site), nurses, and patient support groups.

All Hong Kong citizens will have an extract of their own electronic health record (eHR). They will be able to study it themselves, and it will be designed to be much more user-friendly. It will tell them about their past vaccinations, the results of previous health screening tests, their allergies, pathology and digital X-ray results, and it will chart key aspects of their health to point to warning signs, such as blood pressure, weight, and cholesterol levels.

In 2020 patients will go to hospital less often. Through managing their own health better, there will be less need for repeat hospitalisation. Many of the high-tech services, such as renal dialysis and mechanical ventilation, will be delivered at home. Before a person decides whether to go to the Accident and Emergency Department, they will ring a triage nurse for an initial assessment, or they will do their own assessment using a triage logarithm available on the internet.

Of course, there will be an increase in community nurses, and specialised teams will be formed to focus on those at the highest risk of re-hospitalisation because of the severity of their condition.

Patients will administer many diagnostic tests themselves, including pathology, glucose testing, and blood pressure. They will enter their results into their own eHR, where it will be graphed and generate automated advice or warnings (based on the most recent clinical research) about what they should do to improve their health. Some level of warnings will be automatically dispatched to their carers and key health workers, either a doctor or a nurse.

Perhaps some medications will be automatically dispatched to their home based on these test results and the advice generated by the eHR, rather than requiring the person to attend an outpatient clinic for repeat prescriptions only.

Of course, new technologies and treatments will emerge. Some will arise from the mapping of the human genome, and by 2020 there will be some personalised medication based on your risk factors determined by your unique genome sequence. The Massachusetts Institute of Technology (MIT) recently produced its 10 most exciting emerging technologies from all industries for 2007. Nine of the ten have their most immediate use in

healthcare, and apart from personalised monitors, include: compressive sensing in MRI systems that capture images up to 10 times more quickly than now; neuron control "switches" that turn selected parts of the brain on and off for treatment of depression; single-cell analysis that will give better prognostics for cancers; nanohealing that stops bleeding almost instantly; and anti-ageing genetics research for slowing or preventing dementia.

This is just a taste of what we can expect for the future. Our community will demand that Hong Kong have the latest in medical technology, and our clinicians will respond positively as they have in the past.

HA patients will stay in an acute hospital for a very short time. If they have surgery, almost all will return home on the same day of surgery. If a person has more complex medical or surgical needs, they will be transferred to a sub-acute facility for rehabilitation or convalescence after a short period in the acute hospital for treatment and stabilisation.

In summary, the 2020 patient will be much more in control of their health, and have a wider range of service options from which to choose.

HA 2020 — FROM THE HA STAFF'S PERSPECTIVE

Of course, our empowered patients will present challenges for HA colleagues. But by 2020 we should create an environment where staff are well prepared and in fact leading the way for the new HA customer.

Staff will be negotiators, not only carers. Instead of being "patient focused", they will be "patient collaborators".

Many staff will find that their workplace is no longer in an acute hospital ward or in an outpatient clinic, but rather out in the community or even on the telephone or home computer screen, or in new day clinics in the hospital. There will be a much more interesting mix of opportunities for staff to work in different settings, as the service models move out from the hospital into the community and people's homes.

Modern technologies and treatment innovation will require staff to be constantly re-trained, with more specific and specialised skills.

HA will become a much more flexible employer in response to the new generation's demands for work-life balance. So rosters and the organisation of work will have changed. Less work will be done in hospitals at night, and roster patterns will finally progress past the days of Florence Nightingale.

As part of the re-building of trust between HA management and staff, there will be more reasonable workloads for colleagues. This will be supported

by new funding systems that reward performance and is based on the standardised cost of delivering similar services.

Finally, by 2020, we should have a rewarding leadership culture in HA. HA managers will set clear directions for their staff, but give their staff flexibility to innovate and take risks about how they achieve the direction set by the leader. Staff attitudes will become as important as financial performance and quality outcomes in determining whether managers are promoted. Leaders will be well trained and have a diversity of experiences throughout their career.

HA colleagues will be proud of working in HA, with its culture of support, innovation, and patient partnership. Because patients and staff are satisfied, the community image of HA will improve, and this will reinforce the positive experience of staff in HA.

SO WHAT ABOUT THE NEXT TWO YEARS?

By this stage, you may be thinking, "Well, that is interesting and he is painting a 'rose garden', but what has it got to do with us in HA in 2007. What can we do now?"

I see five priority strategies for the next two years which should be HA's focus.

Strategy One: Clinical Innovation

If patients are to take control of their health, they need new options — they need HA to introduce clinical innovations.

We have an outstanding model in the past 12 months, with the introduction of Hong Kong's new smoking laws. It encourages people to take responsibility for their own future health and minimises the impact of second-hand smoking. I believe this courageous innovation will do more than anything in recent, and possibly future, times to improve health by pushing responsibility back to the citizen.

HA has a proud record of innovation over many years ---I see it wherever I go. Now is the time to revive and accelerate the value of clinical innovation.

In the 12 months of observing HA, I see some high priority areas for further innovation.

- New programmes that keep people out of hospital through secondary prevention. In HA's budget this year, we have allocated $43 million for 11 innovative programmes that show the way for the future. For

example, the new funds support a multi-disciplinary heart failure management team and a home follow-up programme to reduce re-hospitalisation for congestive heart failure.

- Expansion of community mental health services. Australia, after many years of annual investment growth, has more than doubled its community mental health staff in nine years. If the Australian level was translated into the Hong Kong population, we would have 3,100 community mental health staff. We do not have accurate numbers for Hong Kong because some staff do both inpatient and community care, but HA's data in the Government Estimates report only 117 community mental health staff. Mental health is one of the few major service areas where HA needs to significantly modernise and innovate to align with the rest of the world.

- Innovation is needed with new models of primary healthcare that draw together General Outpatient Departments (GOPDs), community nursing services, and allied health staff into an integrated team. Patients using Specialist Outpatient Clinics can increasingly be "downloaded" to General Outpatient Clinics (GOPCs) and family medicine clinics.

- Building up of sub-acute services, particularly rehabilitation clinics and programmes for people making the re-entry to home.

- More public-private initiatives that offer more choices, including innovative models within HA facilities. The private sector is experiencing high occupancy, and some private doctors are struggling to get access to theatre time and beds in the private sector. The economy is in good shape and people have more income and greater demand for private healthcare. So now is an ideal time to encourage a flourishing of choices for patients, whether in the private sector or in the public sector. HA is still using only 54% of its private beds. There is no intermediate option, where patients on HA waiting lists can pay a little more to be seen more quickly, or to choose a better physical amenity, or choose to have their maid stay longer, or even choose their own private doctor in the public hospital. We should seek to give control back to the patient, and let them make their choice, rather than denying them the opportunity by continuing with the same current set of narrow options.

- Use of electronic service delivery, where patients are followed up over the phone or information is delivered directly to patients via the internet. The type of innovation can be illustrated by the High Risk Elderly project in Hong Kong East Cluster. It identified target populations with frequent hospital admissions (three or more) and multiple co-morbidities (three or more). New service interventions

include Telephone Nursing Consultation Service, and follow up by non-governmental organisations, medical social workers, and community nurses. Compared with a control group, the outcome was 37% fewer Accident and Emergency attendances and a 36% less in emergency admissions.

These are some areas where innovation is needed, and I encourage HA staff to look at other areas of clinical innovation to take HA into its next era.

Strategy Two: The Informed Patient

To be more self-reliant and exercise a wider range of choices, patients need access to their own patient information. Hong Kong has a unique opportunity to be the first in the world to offer its whole population access to their own eHR (Electronic Health Record). We need to fast track the next stage of HA's Clinical Management System (CMS III) so that the wealth of patient information in HA can be easily adapted to the wider Hong Kong environment.

HA's Electronic Patient Record Pilot Project needs to move quickly to demonstrate that the private sector can safely access patient data, with tight privacy controls. Currently this involves one-way reading by the private practitioner of HA's information, and it needs to progress to allow private doctors (and eventually patients) to enter information into the record. We will need to overcome trust barriers between the public and private sector, and ensure tight privacy protocols, but an eHR should be achievable within the next five years with sufficient investment.

We should not lose this opportunity to lead the world in empowering our patients to take control of their own health information.

Strategy Three: Consensus on HA's Core Service Offering

We need to gain some consensus about HA's "core service offering". Countries around the world spend varying amounts on healthcare. Hong Kong spends around 5.5% of its GDP (the public and private sector), while the United States spends over 16%. Each society must decide what it wants to offer the community as a universal healthcare right, and these decisions vary greatly between countries.

What should HA do? How should it position itself? It cannot do everything that is possible in modern medicine. We make decisions every day — whether at Head Office or in the ward — about how we will ration our resources, and so what will be the "core service offering" to the Hong Kong community.

Decisions about HA's core service offering should be made openly,

engaging the wider community. These decisions take the form of what will be "self-financing" or how long someone will wait for a service — the performance pledge to the community.

We must continue to provide a quality service. Occasionally I hear people say we should reduce demand by providing low quality services, such as making people wait a long time. I do not support this view, and believe HA's "core service offering" should be high quality, including continuing service modernisation.

In fact, we must develop better ways of measuring the quality of our services, including waiting times for non-urgent services where we have no performance pledge at the moment. The worldwide quality movement has much to teach us about how we can improve services without paying more, and quality often leads to financial savings.

So, what is to be done to better define what the community can realistically expect from HA? The Secretary for Health, Welfare and Food has given us the policy setting in defining the four focus areas for HA:

- acute and emergency care,
- services for low income groups and under-privileged people,
- illnesses that entail high cost, advanced technology and multi-disciplinary professional team work, and
- training of healthcare professionals.

As new technologies and treatments emerge, we must make informed, evidence-based judgements about what should be universally available as part of the 'core service offering', and what has more marginal or unproven benefit.

The HA Drug Formulary presents an excellent model. Using international evidence HA has defined the pharmaceuticals, along with patient indications, that it is willing to offer the community at highly subsidised rates. It covers the proven essential treatments. HA doctors can prescribe outside of the Drug Formulary if the patient makes the choice, and the patient will be expected to provide a co-payment.

So the principle is that if an item is outside of the "HA core service offering", then the level of subsidy should be lower.

We will continue to keep our fees and charges under review so that we can create the right incentives to use HA's service wisely, and give higher subsidy to HA's "core service offering". For example, it should not be more financially attractive to stay in hospital than to be at home or in a residential aged care home. Or use of the Accident and Emergency Department for minor ailments should not be more attractive than using a

general practitioner, whether private or public.

Strategy Four: A People Plan for HA

Perhaps HA's most difficult challenge is to re-engage management and front-line staff. In the past 12 months, I have heard so many examples where staff feel disconnected from management, and this is confirmed in the recent HA staff survey.

What can we do? Over this year we will develop a People Plan for HA. I expect it will have priority action areas.

Reducing doctors' working hours. Alongside our commitment to cap maximum hours to 65 per week, I would like to reduce the maximum continuous shift time from the current 36 plus hours for some doctors to somewhere between 16 and 24 hours. This will involve re-organising work and shift patterns, reducing non-urgent night time work, and changing our on-call systems. Work and rosters should be organised so that doctors required to be in the hospital, as much as possible, will be actively working. Disruption to colleagues' personal lives can only be justified if there is essential work to do at night in the hospital. We are certainly not trying to achieve these targets by making all doctors work 65 hours, and I accept that we will need more doctors.

The HA People Plan will address **nurse workloads**. There are two aspects. First, is there some work that could be done by other care workers and do not require our well trained nursing expertise or can technology help further to reduce nurse workloads? Second, we need new workload standards for our key nursing areas, including wards, theatre, Specialist Outpatient Departments, GOPDs, and intensive care. These workload standards should take account of the dependency of patients on nursing care, and also the potential for non-nursing staff to relieve some workload. The training and recruitment of more nurses at different levels is unavoidable if we are to address workloads.

I recognise the lack of **career progression** as a major source of low staff morale in HA, and the People Plan will propose new career structures for our key professional groups. As our financial position improves, I expect more promotions to be available for our hard-working colleagues. The key principle for career progression and remuneration is that people should get paid in proportion to the work they do and their expertise. The HA value of fairness (i.e. equal work, equal pay) will drive these changes.

Some progress has been made on employment terms and conditions, such as the re-introduction of permanent employment terms, conversion of temporary to contract staff, and creation of new increments. This year we will offer more attractive part-time terms to offer more **flexibility** for staff,

whether it is our female workers who want more family time, or doctors who want to mix public and private sector work. Currently we have only 160 out of 52,000 staff — 0.3% — as part-time employees, and I cannot accept that what this reflects are staff's preferences. More potential for flexible employment arrangements will be explored and encouraged.

HA's People Plan must address **leadership capabilities**. Last year we conducted an "inspirational leadership" programme, and this year we are introducing an intensive top leadership programme using international experts. We will invest more in building up leaders at all levels of HA. I place great hope that the emerging leadership style will re-engage staff and promote a culture of innovation and openness, where colleagues can express their views and ideas without fear of reprisal by managers. Hopefully this will be like opening the windows and letting some fresh air in to HA.

For leaders to grow they need to have different experiences. Yet I am surprised by the lack of movement of senior managers around HA, whether Chiefs of Service, Department Operation Managers, or Hospital Chief Executives. I would like to see more movement of staff across departments, across hospitals, and across Clusters. This will give leaders the opportunity to learn from how others do things. It also creates a culture of innovation as new eyes look at old problems differently, and staff feel that they can bring new ideas forward to a new boss.

We will measure better our "People First" performance through a much more extensive staff survey which will go to the level of department, ward and clinic. This will monitor progress towards achieving a culture where managers sincerely care about the well-being and development of their staff. It will be conducted annually, and will be used to assess manager's performance and to shape promotions.

HA's People Plan will identify what else we need to do to support staff and move us towards the 2020 vision that staff will be proud of working in HA and feel that their work is treasured by their managers.

Strategy Five: New Internal Resource Allocation System

Reasonable workloads can only be achieved if HA's internal resource allocation system funds the services actually delivered by our staff — the number and type of patients treated. Money should follow the patient in HA.

If workload increases within an agreed cap, then funding is increased to employ more doctors, nurses, allied health and supporting staff.

This moves away from the historical rollover resource allocation method,

with all its unfairness and poor incentives for efficiency. So this year we will commence work on a new internal resource allocation model for HA which will be based on activity adjusted for patient case mix.

The same service, such as a hip replacement or endoscopy or specialist medical outpatient visit, will be funded at the same rate regardless of which hospital provides the service. The principle is "same service, same funding". This is a fairer system for staff.

It also promotes efficiency, because a standardised length of stay for each acute inpatient episode is built into the case mix model.

The new system needs to be careful about the incentives it creates. For example, we want to encourage substitution of day surgery and treatment for overnight stays, so reimbursement should reward efficient and modern care practices.

We do not want to encourage excessive inpatient activity — consistent with the aim of reducing avoidable hospitalisation — so we will need to have a cap on patient activity. This should be based on sensible service planning and reflect the highest priority demand growth.

Having established the "HA internal cost or price" for a service, we will then be in a position to decide whether we should contract with the private sector to deliver some services, either because HA does not have the capacity or because the private sector may be more efficient. HA should not fear competition, either internally or externally. We will trial such an approach this year.

CONCLUSION

Whether we want it or not, HA is marching towards the year 2020. Our patients will be more demanding, but also more capable of managing their own health. This is inevitable, and our choice is whether we want to fight it or assist it to happen.

The evidence is that when patients are given the tools to care for their own health, outcomes improve, and hospitalisation declines.

So, my hope is that HA will support and inform patients as partners, offer more treatment choices, and by then I hope we will have our financial incentives right. We must not compromise on quality.

The five strategies over the next two years will put us on the right path towards 2020:

- clinical innovation leading to more choices for patients,

- creating the informed patient through the eHR,
- gaining a consensus on HA's core service offering,
- creating a People Plan for HA, and
- introducing a new HA internal resource allocation system.

We have the opportunity to re-build trust between management and front-line staff, and build a leadership culture that rewards innovation and a caring attitude towards front-line staff. That is our future.

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