CHAPTER 10 – ENHANCED HONORARIUM SYSTEM

1001 The Steering Committee is well aware of the excessive long and unsocial hours of work of frontline doctors. An overall remuneration plan should be developed to induce reduction of unnecessary activities and overnight calls, hence work hours, and redress the prolonged work of doctors during shift and overnight on-site call duties.

1002 HA's present fixed-rate 2-tier honorarium system, inherited from the civil service honorarium system formulated in 1989, adopts a broad-brush approach to avoid meticulous counting of work hours while taking into account the variation of work patterns among different specialties. It serves as recognition to those doctors who are required to work for consistently long hours by nature of their duties. In general, save for some exceptional cases, doctors working in busy clinical units with 24-hour Accident and Emergency Departments receive a monthly honorarium of $3,500 while those working in less busy clinical units or in hospitals without 24-hour Accident and Emergency Departments draw a monthly honorarium of $1,750. Consultants in busy and less busy clinical units receive a monthly honorarium of $1,750 whereas all doctors working in clinical units without overnight on-site call duties are not entitled to the monthly honorarium.

1003 The Steering Committee is pleased to note that, subsequent to a series of constructive discussions between the HA management and members of the Doctors Staff Group Consultative Committee (DSGCC), the Hong Kong Public Doctors' Association and the Frontline Doctors' Union, major achievements were attained in August 2007 in revamping the career structure for HA doctors with the following objectives:

a) To attract graduate doctors to pursue specialist training in HA
b) To motivate and retain specialist doctors through modernized incentives which recognize performance, qualifications, experience and willingness to take up new responsibilities
c) To enhance fairness in processes for career progression and
d) To strike a balance between staff expectations and financial sustainability of HA

1004 Under the new career structure, the Resident pay scale would be revised to cover pay points 30 – 44B under the HA General Pay Scale (HGPS). This would significantly alleviate their concern over "equal work and unequal pay". As Residents progress to pay point 44B over time, those who were recruited after April 2000 would attain "equal work and equal pay" comparable to other Residents and Medical Officers who joined the service in or before 1999. Moreover, all Residents undertaking specialist training would be offered a 9-year training contract, subject to satisfactory performance and attainment of specific training milestones. Smooth progression to permanent employment, which is purely performance-related rather than position-dependent, would follow.

Consultation: Feedback from Respondents

1005 The honorarium system, despite the relatively small amount of money involved, had been a sensitive issue of heated debate in the frontline units. Some clinicians opined that HA's current fixed-rate honorarium system was "unfair", "open to abuse" and insufficient to address the contemporary workload, pay disparity and morale issues among the serving doctors. While some doctors called for a compensatory rate higher than their hourly pay rate, others advocated stipulating a cap on doctors' weekly work hours and compensating them for extra on-site work and off-site call duties done, so as to duly recognize their dedicated work in patient care.

1006 In the Strategic Planning Workshop held in March 2007, frontline participants suggested a "more pay for more work" remuneration system with pre-determined rates to recognize doctors' long and unsocial hours of work. The new pay system should discourage the management from over-rostering doctors and refrain from inducing doctors to lengthen their work hours. In subsequent rounds of staff consultation, certain doctors appreciated the merits of the broad-brush approach of nominal recognition with the ultimate goal of reducing doctors' weekly work hours. However, as some doctors currently on on-site calls would be working off-site under the new work hour arrangements, they also looked for an objective means to define the impact factor of their off-site duties in comparison with on-site work in ascertaining the appropriate level of monthly honorarium.

1007 An opinion was received that, by virtue of the differences among specialties and hospitals, there were inevitably unequal work and considerable variations in work hours and intensity among the clinicians. This was especially true for non-acute and infirmary hospitals which were often associated with low work intensity. Fairness in remuneration was thus hardly achievable and it would be difficult to apply the principle of increased honorarium for more weekly work hours. On the other hand, some doctors considered it fairer to grant monthly honorarium in proportion to their frequency of call / shift instead of average weekly work hours. As each call / shift had to be paid for, the advocated approach had the advantage of preventing over-rostering of doctors in the clinical departments.

1008 The HKPDA and other Doctors' Associations, in their Joint Position Statement, submitted that the defined conditioned hours' should be expressly re-recognized. Besides, they claimed that while it was up to HA to offer financial reward for excess hours worked, doctors still had the right to opt for time-off in lieu, to which they claimed to be entitled. Yet, there were also concerns over the financial sustainability of the honorarium system should salary be adjustable upwards for busy doctors only but not downwards for less busy ones.

1009 Finally, it was suggested that robust data should be collated and evaluated to demonstrate the genuine impacts of reform and resource deployment on optimizing doctors' workload and improving their working conditions.

The Steering Committee's View & Recommendations

1010 The Steering Committee agrees that the present 2-tier honorarium system, while intending to recognize a wide range of doctors' excess work hours, is inadequate to address the variations in work pattern among different call tiers and specialties in different hospital settings.

1011 The Steering Committee respectfully declines the suggestion of the HKPDA and other Doctors Associations that staff may opt for time-off in lieu, since this is neither operationally feasible nor sustainable to ensure quality patient care and safety. Staff should continue to follow the prevailing HA human resources policies.

Principles of Recognizing Doctors' Excess Work Hours

1012 The Steering Committee well understands the clinicians' concerns and holds a similar belief for a "more pay for more work" remuneration system as proposed by the frontline doctors. It seeks to enhance the current honorarium system in order to better address the variations in work patterns among doctors in different call tiers, specialties and hospital settings. Yet, work intensity has not been a focus of reform, since absolute fairness is barely achievable, given the intrinsic differences among specialties and even within the same specialties across hospitals.

1013 The Steering Committee considers the following principles instrumental to recognizing doctors' excess work hours:

a) The key principle underlying the enhanced honorarium system is that honorarium should serve as **recognition instead of an incentive** for doctors' excess work hours. The honorarium system should be so designed as to discourage the management from over-rostering their staff and disincentivize doctors to self-generate work for higher pay. The key aim of the honorarium system is to bring about quality doctor hours for medical services and professional training in place of tired workers tendering patient care with inherent risks.

b) Doctors' excess work hours should be recognized both **financially and nominally**. The Steering Committee agrees to the frontline staff's advocacy of "more pay for more work" but considers that any enhanced remuneration system should be within a mutually agreed framework.

c) Doctors should **not be worse off** under the enhanced honorarium system. The current honorarium system should be critically reviewed in order to adequately recognize doctors' dedicated contribution and retain them to provide quality patient care services for the community.

d) Given finite resources, **sustainability and affordability** should be taken into account in financially recognizing doctors' excess work hours.

Two Approaches to Recognizing Doctors' Excess Work Hours

1014 Based on the views and suggestions from respondents and prospective expectation of doctors' work patterns in different specialties, the Steering Committee considers that there are two major approaches to recognizing doctors' excess work hours.

A) Nominal Incentive System Rewarding Excess Work on an Hour-to-hour Basis

1015 The hour-to-hour incentive system, as its name suggests, retrospectively remunerates doctors according to their excess hours worked. In other words, the more hours a doctor works, the more he / she earns. It has the merits of compensating individual doctors for their excess hours worked and reflecting such variations among different call tiers and specialties. Yet, it also involves meticulous counting of work hours, incentivizes exhausted doctors to work even more for higher pay and unavoidably creates conflicts and disputes between the management and the frontline over work arrangement and work hour calculation. Care must be taken to quantify work in different specialties, and the system is bound to create specialty discrimination and even augment the pay variance among doctors.

1016 Overseas experience has shown that "it is most risky remunerating for excess hours as it creates a clear incentive to maintain or even increase doctors' work hours"[10.1]. In the UK, the resources used in remunerating doctors for their escalating excess work hours have much surpassed the sum planned under the new pay banding system. Besides, "even now there are employment tribunals where individual doctors or groups of doctors are seeking to stop their employers from reducing the number and intensity of hours simply because they want to protect their earnings.[10.2]" The Steering Committee well appreciates certain frontline doctors' cognizance of the drawbacks of hour-to-hour compensation and strongly believes that such an incentive system will put doctors, patients and the whole public healthcare system at risk. It is not the right direction that HA should head for.

B) Broad-brush Nominal Recognition System

1017 To better address the disparity in honorarium in recognizing doctors' excess work hours in different specialties, the Steering Committee recommends HA to consider enhancing the present honorarium system that has been put into use for 18 years. Instead of creating a brand new system, the current broad-brush approach will be maintained in nominally recognizing doctors' excess work hours. Two optional parameters, namely doctors' average weekly work hours and frequency of call / shift in a month (as frontline doctors have suggested), can be considered in determining the honorarium for doctors in different call tiers and specialties. The enhanced honorarium system is suggested to carry the following features:

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a) **Evidence-based and prospective work pattern** - This entails an honorarium system formulated on the prospective expectation of the average weekly work hours or call / shift frequency of doctors in different call tiers, specialties and hospital settings rather than retrospective compensation for their actual hours worked or calls / shifts taken within a certain period. This would avoid induction of over-rostering or self-generating work for higher pay, reduce meticulous counting of work hours or calls / shifts and minimize disputes over the work arrangements and calculations between the management and the frontline doctors. The amount of resources required for paying the enhanced honorarium can thus be defined, thereby rendering the public healthcare system sustainable in the long term. Relevant data can be gathered from baseline surveys or, as a start, from findings of the HA-wide surveys on doctors' work hours conducted in September 2006.

b) **Expanded tiers of honorarium** - It is suggested to expand the tiers of honorarium in order to better differentiate the varying workloads of doctors, translated into average weekly work hours or monthly call / shift frequency, subject to the cap of 65 hours in a week on average. A broad-brush approach may be adopted to nominally recognize doctors' excess work hours. It is expected that doctors possessing comparable levels of competence (or simply put, at the same stage of their career) and working in similar call tiers, specialties and hospital settings would share similar work patterns and draw a similar rate of monthly honorarium. Thus, junior doctors who take on more overnight on-call duties / shifts, hence more weekly work hours, will enjoy a higher rate of monthly honorarium whereas senior doctors with fewer overnight on-call duties / shifts will take a lower rate of monthly honorarium. This is in line with the "more pay for more work" principle and may redress the insufficiency of the current 2-tier honorarium system in recognizing doctors' excess work hours. On the other hand, doctors who currently do not receive a monthly honorarium, for example, due to absence of or minimal overnight on-call duties / shifts, will continue to be ineligible for the monthly honorarium under the enhanced honorarium system.

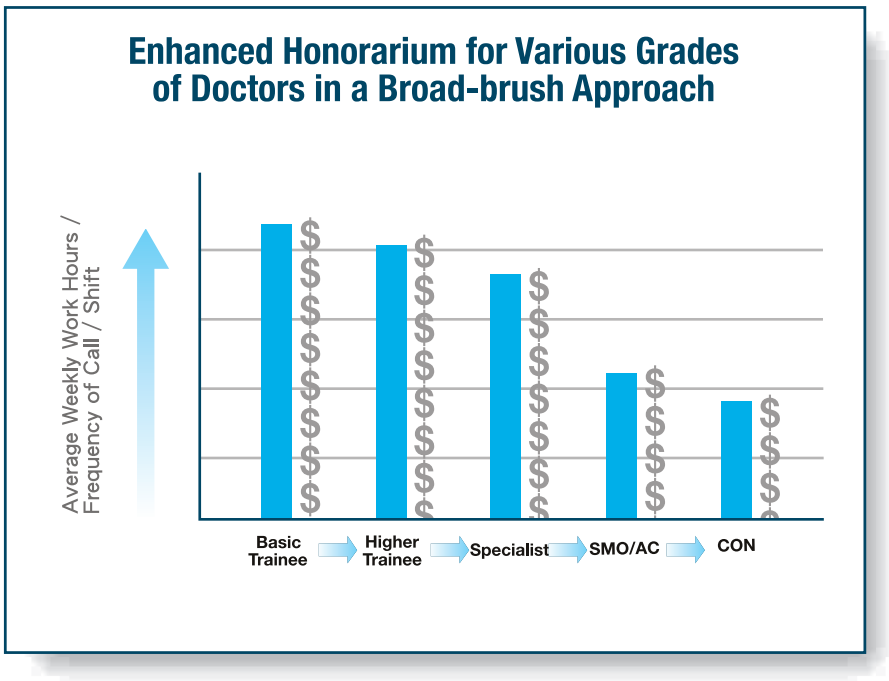
c) **Regular review** - Doctors' work hours or call / shift frequency may be reviewed every 2 to 3 years, so that the enhanced honorarium system will evolve with the changing mode of operation of different specialties brought about by the reform implementation. Flexibility is thus maintained while the enhanced honorarium system will continue to be supported by evidence.

Illustrations

1018 As discussed above, the enhanced honorarium system using the broad-brush approach to nominally recognize doctors' excess work hours can be developed with reference to 2 different parameters, namely, **(1) doctors' average weekly work hours and (2) frequency of call / shift per month.**

1019 Figure 10.1 demonstrates how the overall enhanced honorarium system works, where junior doctors working for more average weekly work hours, taking on more calls / shifts per month or working in busier units will draw a higher rate of monthly honorarium than their seniors or counterparts working for fewer hours, taking on fewer calls / shifts or working in less busy units. The level of honorarium is defined for different grades of doctors and goes down when doctors progress in their level of competence and the career ladder. Hence, the descending honorarium will be compensated by the salary increase along with their years of service and career advancement, so that their take-home pay will not be less than before. Specialty variations in doctors' work patterns will be taken into account and a broad-brush enhanced honorarium system as such will be a predictable and sustainable solution to address the drawbacks of the current honorarium system.

(Fig. 10.1)



1020 On the other hand, Figure 10.2 shows the enhanced honorarium granted in the multiples of $X (e.g. $X - $4X) for various grades of doctors in 4 different specialties on the basis of their average weekly work hours; whereas Figure 10.3 illustrates the honorarium granted in the multiples of $Y (e.g. $Y - $4Y) on the basis of their frequency of standardized call / shift per month. Doctors at comparable levels of competence are thus differentiated according to their varying work patterns; and it is the Steering Committee's aim that HA doctors will not work for more than 65 hours in a week on average by the end of 2009. All their excess work hours, translated into average weekly work hours or monthly calls / shifts, will be nominally recognized under the enhanced honorarium system that adopts a broad-brush approach. It should be reiterated, however, that both average weekly work hours and the frequency of call / shift per month are proposed yardsticks for describing doctors' work patterns and defining the banding of doctors in different call tiers and specialties under the enhanced honorarium system only. They are not meant for any compensatory purpose.

(Fig.10.2)

Option 1 – Honorarium Based on Average Weekly Work Hours

Specialty	Call Nature in General	On-site	On-site	On-site / Off-site	Off-site	Off-site
	Rank	Basic Trainee/ Non-fellow / Non-trainee	Higher Trainee	Specialist (Resident / MO)	SMO / AC	CON
A						
B						
C						
D						

Average Weekly Work Hours	45-49.9	50-54.9	55-59.9	60-65
Monthly Honorarium	$X	$2X	$3X	$4X

(Fig.10.3)

Option 2 – Honorarium Based on Frequency of Standardized Call / Shift Per Month

Specialty	Call Nature in General	On-site	On-site	On-site / Off-site	Off-site	Off-site
	Rank	Basic Trainee/ Non-fellow / Non-trainee	Higher Trainee	Specialist (Resident / MO)	SMO / AC	CON
1						
2						
3						
4						

No. of Standardized Calls / Shifts*	1-2	3-4	5-6	7-8
Monthly Honorarium	$Y	$2Y	$3Y	$4Y

* No. of calls / shifts needs to be standardized due to heterogeneity of calls (short vs long, on-site vs off-site, etc.)

Analysis

1021 The Steering Committee is certainly cognizant of the limitations of this enhanced honorarium system. Given the varying work patterns in different call tiers, specialties and hospital settings, there are bound to be inequities at the individual level under the broad-brush approach, where individual doctors working for more hours or taking on more calls / shifts may earn the same as other colleagues at comparable level of competence. Moreover, this enhanced honorarium seeks to recognize excess work hours rather than intensity of work in different specialties. Pre-defining the notional number of hours worked or calls / shifts taken may carry the risk of creating a "clock-off" expectation or culture among colleagues. However, the Steering Committee believes that HA doctors are highly professional and will continue to dedicate their efforts to quality patient care.

1022 On the other hand, to yield the intended result and attain greater fairness among doctors in different specialties using the frequency of call / shift per month, HA needs to tackle the heterogeneity of doctors' on-call system and the complexity of their call types in different specialties in different hospitals. Irregular hours of long and short calls are currently entailed and diverse nature of on-site and off-site calls are involved, not to mention the varied shift patterns in a number of specialties. The call systems among different specialties and the shift patterns at different work sites have to be aligned. Besides, the financial implications on the entire organization, coupled with possible disputes over work hour calculation and call / shift arrangements, should not be neglected.

1023 In fact, according to the UK experience, it is most risky to link work hours with pay as it would possibly create conflicts between the management and the frontline doctors and induce longer hours of work. Having balanced equity with sustainability concerns and considered the need for a right system to recognize doctors' excess work hours, the Steering Committee recommends HA to adopt a broad-brush approach rather than an hour-to-hour incentive system. In essence, the enhanced honorarium system should be evidence-based and retains the spirit of the current honorarium system in nominally recognizing those who work for the most hours or take the most calls / shifts on average. It also needs to address the insufficiency of the current honorarium system and create greater differentials in honorarium rates for doctors and specialties with varying work patterns. Manipulation of the system can be minimized with a prospective expectation of the doctors' average weekly work hours or frequency of call / shift per month rather than meticulous counting of their actual hours worked. Besides, it will not create a perverse incentive for doctors to work more for higher pay, and no doctor will lose out under the enhanced honorarium system, which has a defined and cash-limited cost of implementation.

1024 In fact, work hours and call / shift frequency correlate closely to each other. Working on an honorarium system that is based on either parameter would carry similar problems and bring about similar results. The Steering Committee is aware of the deficiency of both parameters and is open to the suggestion of formulating the enhanced honorarium system on the basis of the weekly work hours or call / shift frequency of doctors in general, so far as the principles of recognizing doctors' excess work hours as mentioned in Paragraph 1013 above are adhered to and the enhanced honorarium can better address the inadequacies of the current honorarium system and bring forth greater fairness among doctors in different call tiers, specialties and hospital settings. HA is recommended to continue exploring a sound and appropriate **enhanced honorarium system** to recognize the excess work hours of doctors in different call tiers, specialties and hospital settings.

1025 The Steering Committee certainly understands that each specialty has its own work pattern and mode of operation and variations are particularly prominent among specialties in the University and general hospitals. Nonetheless, clinical heads should have the authority and flexibility to regulate work arrangements in the departments so that doctors' excess work hours are justified for service and training needs, and the difference in work hours among doctors in similar positions can be minimized under this enhanced honorarium system. The Steering Committee recommends HA to **monitor and benchmark doctors' average weekly work hours** regularly so that greater equity and volatility can be attained in recognizing the committed work of public hospital doctors in the organization.

Complementary Measures

1026 The Steering Committee is pleased to note that HA has recently taken a great leap forward in tackling the pay disparity among serving doctors by implementing the starting salaries review and revamping the career structure for HA doctors recruited since 2000. The heavy workload of frontline doctors is also partly relieved through the Flexible Employment Strategy of employing part-time doctors to work in public hospitals. Nonetheless, these are not the single means to handle the issues. The Steering Committee believes that promotion of doctors should be encouraged in HA, taking into consideration their competence, qualifications, years of service and acceptance of new responsibilities. Besides, as the financial position of HA improves, more promotion opportunities should be available for doctors[10.3]. HA may consider expediting career progression for its serving doctors so that the working conditions and promotion opportunities can be further improved, thereby boosting staff morale and ultimately rebuilding trust between the HA management and all its dedicated doctors.

[10.3] P.9, Keynote Address by Chief Executive, Hospital Authority at the HA Convention 2007