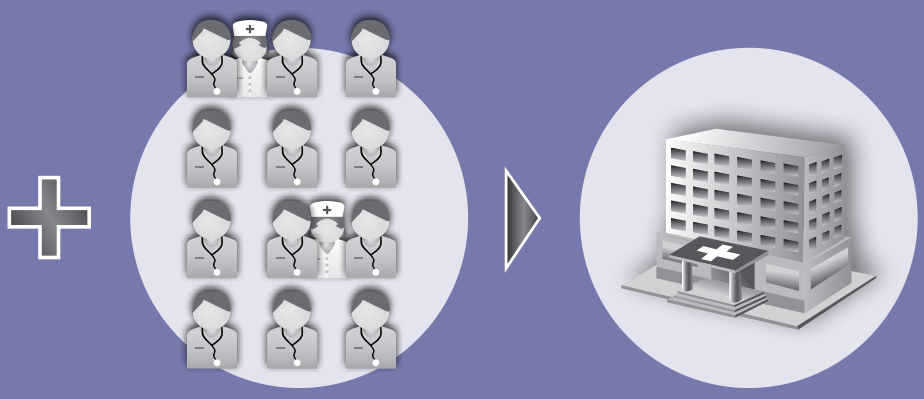
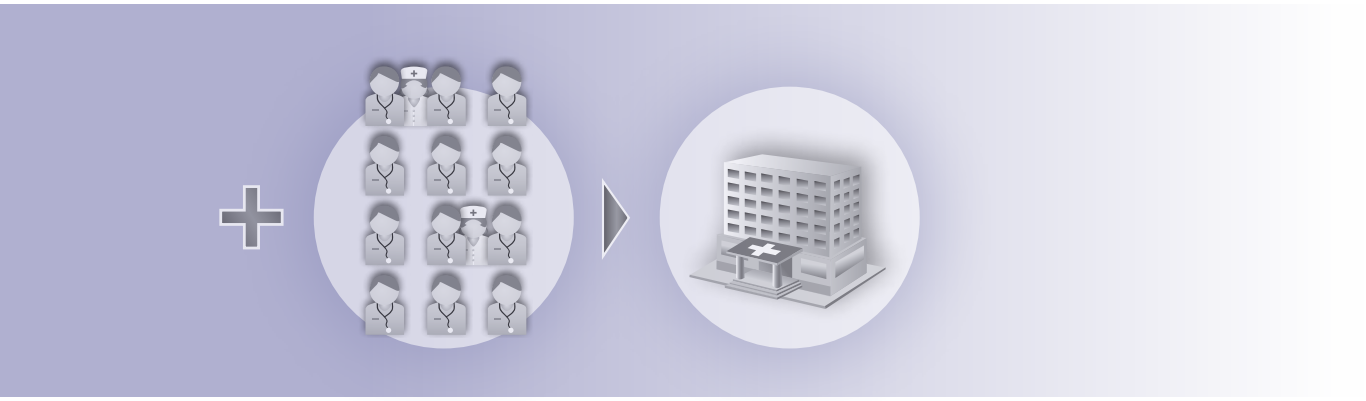
2 Deployment of Doctors to Pressurised Areas



Strategic workforce deployment and public-private partnership to manage rising workload



EXECUTIVE BRIEF

201 Deployment of resources and manpower was a key strategy under Doctor Work Reform to improve the working conditions of doctors and ensure the quality of care and patient safety. HA set aside a total of $182 million from 2007/08 to 2009/10 and supported the creation of 348 new posts, including 38 doctors, to launch various reform-related programmes. There was a net increase of 289 doctors (i.e. 6%) in HA from July 2007 to July 2009, with 121 doctors (i.e. 42% of 289 doctors) deployed to the six pressurised specialties with prolonged doctor work hours. Besides, HA allocated a total of 70 new Resident Trainees to different specialties in 2008/09 and 2009/10 and had acceded to all hospital clusters' requests for allocating Resident Trainees in 2009/10 in order to attain the work hour targets. Despite the hiccups encountered by the pilot hospital in recruiting part-time private practitioners to help out in the surgical out-patient clinics under the then booming private market, HA kept on drawing in private expertise through the contemporaneous flexible employment strategy and public-private partnership programmes to tackle both the increasing workload and staff wastage in public hospitals. The number of part-time doctors employed by HA had risen from 29 in March 2007 to 44 in July 2009.

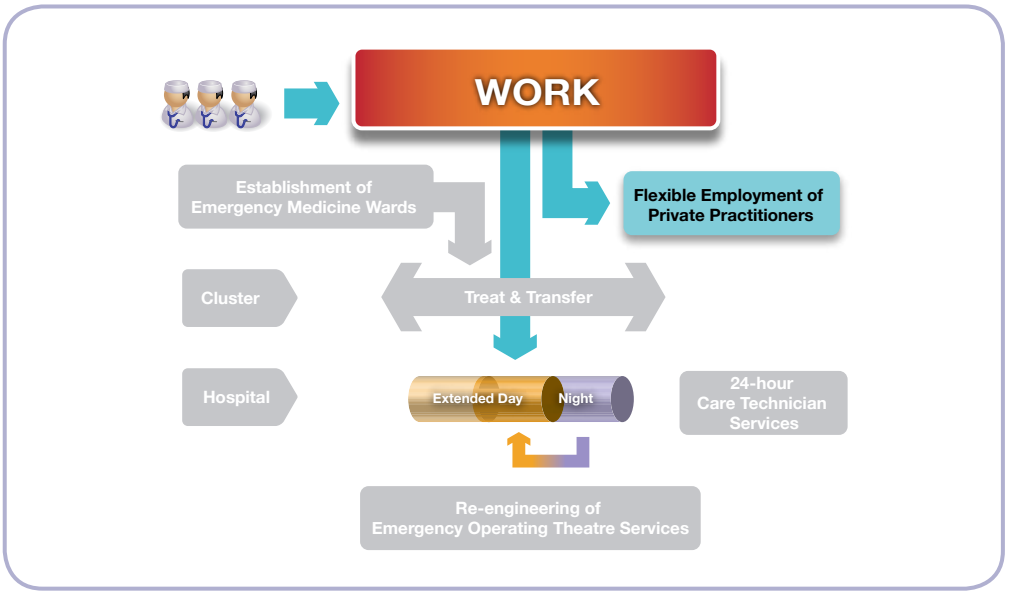
202 HA was recommended to continue deploying additional doctors to the pressurised specialties with reference to the working conditions of doctors in different specialties, alongside the projected growth of service demand and workload as well as the forecasted turnover rate of health carers. Public-private partnership would continue to be the cornerstone for sustaining the public healthcare system in the long run. HA was thus recommended to explore different means of collaboration with the private healthcare sector and develop Family Medicine Specialist Clinics in order to alleviate the workload of public hospital doctors while the manpower level, work arrangements and call systems of doctors in different specialties should

continually be reviewed in order to identify any possible room for optimising workload, streamlining work procedures and improving doctors' working conditions in public hospitals.

PILOT WORK REFORM PROGRAMME

203 HA realised that the undesirable prolonged work hours and heavy workload of public hospital doctors stemmed from an escalating service demand, shortage of manpower and significant public-private imbalance in the healthcare system. Mere changes in doctors' work patterns without additional resource and manpower support could hardly bring about a marked improvement in doctors' working conditions. Thus, to attain the reform objectives, HA adopted three approaches to deploy resources and manpower to pressurised areas, viz. (a) addition of doctors for launching key pilot work reform programmes, (b) addition of doctors to pressurised clinical specialties and (c) employment of private practitioners through the contemporaneous flexible employment strategy. (Figure 2.1)

Fig. 2.1 – Deployment of Doctors to Pressurised Areas



A. Addition of Doctors for Launching Key Pilot Work Reform Strategies

204 HA set aside a total of $182 million[3] from 2007/08 to 2009/10 to launch the key pilot work reform strategies of re-engineering the emergency operating theatre services, establishing Emergency Medicine Wards and introducing care technician services as well as other supportive work reform programmes in various public hospitals. 348 new posts were created under these programmes, comprising 38 doctors, 57 nurses, 21 allied health professionals and 232 supporting grades of staff; and including 26 upgraded posts in various disciplines. In general, the pilot work reform strategies had alleviated the workload of frontline doctors and night-time activities, and created room for revamping the existing work patterns of doctors in different clinical specialties. As a result, doctors had more time to receive training on their core competency which would in turn enhance the quality of care and patient safety. Healthcare professionals also had better promotional opportunities and improved morale. The outcome of the pilot work reform strategies would be discussed in greater detail in the ensuing chapters.

B. Addition of Doctors to Pressurised Clinical Specialties

205 Certain clinical specialties of public hospitals were obsessed by prolonged doctor work hours, grave manpower shortage and high turnover of the medical workforce in recent years. They might not be able to fully benefit from the pilot work reform strategies due to their intrinsic demand nature where night activities did not drop after midnight. This had made trimming or reshuffling of night activities to the extended day immensely difficult. Examples were some obstetric and neurosurgical operations as well as acute paediatric conditions. In this relation, HA had augmented the manpower provision in different pressurised clinical specialties according to their service needs and workforce conditions in the past years. There was a net increase of 289 doctors (i.e. 6%) in HA from July 2007 to July 2009, with 121 doctors (i.e. 42% of 289 doctors) deployed to the six pressurised specialties of public hospitals[4] (Table 2.1 and Appendix XIII).

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[3] The resource allocations for reform-related programmes in 2007/08, 2008/09 and 2009/10 were $31 million, $77 million and $74 millions respectively.

[4] According to the work hour survey conducted in 2006, the six pressurised specialties were Neurosurgery, Surgery, Obstetrics & Gynaecology, Paediatrics, Orthopaedics & Traumatology as well as Internal Medicine.

Table 2.1 – Headcount Changes in Pressurised Clinical Specialties

	July 2007	July 2008	July 2009	Headcount Change (July 2009 Vs July 2007)
HA Overall	**4,799**	**4,952**	**5,088**	**+ 289 (6%)**
Neurosurgery	77	88	90	+ 13 (17%)
Surgery	441	454	482	+ 41 (9%)
Obstetrics & Gynaecology	203	207	217	+ 14 (7%)
Paediatrics	302	306	318	+ 16 (5%)
Orthopaedics & Traumatology	290	295	303	+ 13 (4%)
Medicine	1,100	1,121	1,125	+ 25 (2%)

206 Besides, HA allocated a total of 70 new Resident Trainees to different clinical specialties in 2008/09 and 2009/10 (Appendix XIV) and had acceded to all hospital clusters' requests for allocating Resident Trainees in 2009/10 in order to specifically address the workload issues of doctors and create room for changing their call systems and work patterns. The Steering Committee was glad to learn that the proportion of outliers working for more than 65 hours per week on average in HA dropped from around 18% in September 2006 (involving around 900 doctors in 12 clinical specialties) to 4.8% by the end of December 2009 (involving 252 doctors in 10 clinical specialties), alongside other pressurised areas that had fully attained the work hour targets by the end of 2009 through deployment of additional doctors and launch of various work reform related programmes. The number of overnight on-site on-call doctors who did not have immediate post-call time-off also dropped from 120 in September 2006 to 36 and 39 on the snapshot holiday (July 1) and weekday (July 8) respectively in 2009.

C. Employment of Private Practitioners through The Flexible Employment Strategy

207 Under this pilot programme, HA planned to employ part-time private practitioners under the flexible employment strategy to take up a certain proportion of specialist outpatient consultation sessions and handle a specified minimum of selected cases at a pre-determined rate of remuneration. It was targeted to relieve the rising service volume and tackle the high turnover rate of public hospital doctors in recent years. Clinical specialties could then lessen the need for doctors to attend outpatient consultations after their overnight on-site on-call duties and have greater room for revamping their work patterns, like granting post-call time-off to the overnight on-site on-call doctors, so that they could concentrate on their core medical and inpatient care duties. Besides, patients would have more service choices in the private market as to relieve the lingering issue of public-private imbalance in healthcare delivery.

208 However, recruitment difficulties were encountered under the booming private market in 2008, despite repeated attempts and promulgation among the private practitioners via the Hong Kong Doctors Union. Since late July 2008, a doctor had been internally deployed from the Accident and Emergency Department to support 8 sessions of surgical outpatient clinics per week in the pilot hospital[8]. The arrangement was in general welcomed by the frontline doctors, for it provided a steady workforce and facilitated granting of post-call time-off for the second on-site on-call doctor in the Surgery Department. The pilot programme ended in July 2009 when additional Resident Trainees were allocated to the said department to attain the work hour targets. All on-site on-call doctors could now enjoy immediate post-call half-day time-off, hence reduced continuous and average weekly work hours for delivering quality and safer patient care.

[5] The deployment was made in Princess Margaret Hospital.

209 The hiccups in recruiting part-time private practitioners to help out the surgical outpatient clinics did not undermine nor impede HA's initiative to draw in private expertise to support the public hospital system. The number of part-time doctors employed by HA had risen from 29 in March 2007 to 44 in July 2009, spreading across 14 clinical specialties like Accident and Emergency, Anaesthesia, Family Medicine, Medicine, Obstetrics & Gynaecology, Paediatrics and Surgery. Moreover, various public-private partnership programmes were also in place, like the Cataract Surgeries Programme[6], the Tin Shui Wai Primary Care Partnership Programme[7] and other shared care programmes, to offload the rising service volume to the private sector with positive outcomes. Given the financial tsunami currently hitting the global economy, it was pondered that there should be less difficulty in recruiting part-time private practitioners, whose service would ultimately benefit both patients and the frontline doctors.

ISSUES OF CONCERN

210 Deployment of doctors to pressurised areas was a pragmatic means to alleviate the workload of frontline doctors. In particular, the overall service volume in public hospitals was alleviated by reducing avoidable admissions, reshuffling non-emergency night operations to the extended day and collaborating with the private healthcare sector to handle part of the specialist outpatient consultations. Frontline doctors in certain clinical specialties could work less intensely at night and for fewer hours at one go, thus able to provide safer inpatient care and receive better training in a more vigilant state.

211 Nevertheless, addition of doctors should not be taken as the single solution to address the workload and work hour issues of frontline doctors in different clinical specialties. HA should keep on rationalising its hospital services, streamlining work procedures, fostering multi-disciplinary collaboration in care delivery, developing service networks across clusters for highly sub-specialised services where appropriate and, above all, introducing practical means of operation and revamping doctors' existing work patterns in order to truly alleviate the service volume and improve doctors' working conditions.

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[6] The Cataract Surgeries Programme aimed to shorten the central waiting list for cataract surgeries by subsidising eligible patients to get the surgeries done in the private sector. By the end of September 2009, 80 private Ophthalmologists and 8,582 patients had been enrolled in the programme.

[7] Under the Tin Shui Wai Primary Care Partnership Programme, HA would purchase primary care services from private practitioners for specific patient groups, like hypertension, diabetes and osteoarthritis, in the Tin Shui Wai District. By the end of September 2009, 6 private practitioners and 1,123 patients had joined the programme.

212 Besides, since an expanded workforce would bring about career progression hence morale problems among the junior doctors, HA should strategically deploy doctors to pressurised areas on a need basis, taking into account the competing service demands, supply of medical graduates, trainee admissions in different specialty colleges, manpower wastage, doctors' working conditions as well as service sustainability for the entire organization in the long run. Yet, in order to support the revamped arrangement of strengthened off-site specialist support for on-site on-call doctors, and to improve clinical supervision in public hospitals during out-of-hours, HA might consider, subject to resource availability, enhancing the staff mix and creating an appropriate number of senior clinician posts in busy specialties. This would also improve the promotional opportunities and morale of frontline doctors, especially those in the middle call layer who had out of their professionalism taken up extra work and call duties for attainment of the corporate work hour targets.

213 A number of doctor representatives queried HA's manpower deployment strategy and suggested that doctors should be deployed direct to the pressurised specialties rather than to the Accident and Emergency Departments, for the latter's gate-keeping function was questionable and the EMW initiative merely denoted a redistribution of workload from the medical wards without reducing acute admissions to other clinical specialties. The Steering Committee was cognizant of the teething problems and confounding factors, like inadequate hospital beds, varied operational modes, insufficient cross-specialty collaboration and epidemic outbreak since the second quarter of 2009, which hindered full attainment of the programme objectives at certain pilot reform sites. Yet, the EMW was proven effective in providing quality and fast-track care for short-stayed patients and was a suitable platform for multi-disciplinary and cross-specialty collaboration in managing selected acute patient conditions, while the clinical wards would focus on managing medical problems which required respective specialists' expertise. When the confounding factors were resolved (please refer to Chapter 4 for details) and there was closer collaboration among the clinical specialties, deployment of doctors to run the EMW initiative would maximise the patient outcome and the right care could be delivered to patients in the right place.

214 On the other hand, following the feedback of the Family Medicine Coordinating Committee, HA might consider setting up Family Medicine Specialist Clinics in public hospitals with appropriate resource support in order to manage patients with multiple chronic illnesses in a holistic approach. This would not only reduce the specialist outpatient workload of doctors in pressurised clinical specialties, but also improve the professional development and career opportunities for trainee doctors in this specialty. On the other hand, certain hospital management opined that Family Medicine physician training should be geared towards quality patient care which required more training time. The current arrangement of deploying the limited workforce of general outpatient clinics to manage ad hoc clinical activities (e.g. melanine-tainted milk, human swine influenza) could be undesirable for doctors' specialist training. The overlap of work done by the general and specialist outpatient clinics should be avoided.

215 Public-private partnership would continue to be the cornerstone for optimising the total workload and sustaining the public healthcare system in the long run. HA should explore further room of collaboration with the private sector so as to alleviate the workload of frontline doctors and improve the quality of care and patient safety in public hospitals. More promulgation to the patient groups was required, as were well-thought mechanisms to facilitate patient referral to the private sector and enhance system support through information technology, like development of an electronic platform to share health records and information between the public and the private sectors, so that the continuity and quality of patient care could be enhanced. Moreover, development of ambulatory and community care was a global move in the healthcare sector as to reduce avoidable admissions and hospitalised care, hence workload of doctors. HA might consider further development in this direction in order to manage its rising service volume.

216 Finally, as a hospital management staff had expressed, the existing unstable workforce of HA might not be able to sustain the ever increasing public demand. HA might need to define a limit to its scope and depth of service in order not to affect the quality of public healthcare services for the general public.

THE STEERING COMMITTEE'S RECOMMENDATIONS

217 The Steering Committee put forward the following recommendations in relation to the deployment of doctors to pressurised areas:

a) HA was recommended to continue deploying additional doctors to the pressurised specialties with prolonged work hour issues via the established Resident Trainee allocation mechanisms and plan its workforce with reference to the competing service demands, supply of medical graduates, trainee admissions in different specialty colleges, manpower wastage, doctors' working conditions as well as service sustainability for the entire organization. This would even out the average workload of frontline doctors in different specialties and improve their working conditions and morale. Moreover, better and safer care could be delivered by more vigilant doctors in public hospitals.

b) HA was recommended to continue exploring different means of collaboration with the private healthcare sector, developing Family Medicine Specialist Clinics and engaging in further public-private partnership programmes, in order to alleviate the workload in the public sector and ensure the quality of care and safety for public hospital patients.

c) HA was recommended to continue rationalising its hospital services, streamlining work procedures, reviewing its manpower level and work arrangements, and fostering multi-disciplinary collaboration in care delivery in order to identify any possible room for optimising workload and improving doctors' working conditions in public hospitals.