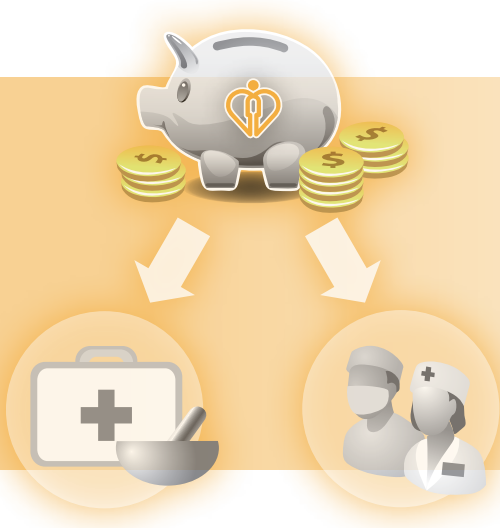
8 Targeted Deployment of Resources

Strategic and prudent deployment of resources
for better care and greater work recognition



EXECUTIVE BRIEF

801 *Following the recommendations of the Steering Committee in November 2007, HA had embarked on a series of pilot Doctor Work Reform programmes since the end of 2007 in order to verify their effectiveness in attaining the reform objectives of quality care through teamwork, risk management for enhanced patient safety as well as quality doctor hours for service and training. Seed money at the sum of $182 million[45] had been injected in the pilot programmes, supporting 348 new posts of doctors, nurses, allied health professionals and other supporting grades of staff in different hospital clusters. Moreover, an additional pool of 70 Resident Trainees were allocated to various pressurised clinical specialties in 2008/09 and 2009/10 in order to specifically address the workload issues of doctors; and the total headcount of HA doctors had actually risen by 471, from 4,617 in March 2007 to 5,088 in July 2009. It was HA's target to reduce all doctors' average weekly work hours to not exceeding 65 while ensuring the quality of care and patient safety in public hospitals, and the target was largely attained as to render a more vigilant and competent workforce for delivering quality and safe care under the ever rising service demand, global economic downturn as well as outbreak of epidemics in recent years.*

[45] Seed money in the sum of $31 Mn, $77 Mn and $74 Mn was injected in 2007/08 (half-year), 2008/09 and 2009/10 respectively to launch various pilot work reform programmes.

802 *As the experience of the pilot work reform was consolidated, HA was recommended to roll out various pilot work reform strategies in other public hospitals where appropriate, and strategically and prudently deploy its resources so as to maximise the outcome of work reform in improving both doctors' work-life balance and the service outcome. While HA was recommended to continually explore different ways to reconfigure its hospital services and rationalise its service provision; resource utilization should be prioritised for those programmes that had a greater potential for increasing the system efficiency, optimising workload, enhancing the quality of care and patient safety as well as improving staff morale. In this connection, HA was recommended to formulate an enhanced honorarium system which could duly recognise doctors' excess work in a broad-brush and nominal approach, taking into consideration the organization's affordability and sustainability in the long run; and to supplement the enhanced honorarium system with the established special honorarium scheme in order to recognise frontline doctors' contribution to ad hoc clinical activities.*

PRINCIPLES OF RESOURCE DEPLOYMENT

803 The Steering Committee had envisaged the adverse impacts brought by the recent financial tsunami, and forecasted a downward spiral that would affect the local healthcare market. Further constrained by the decreasing supply of medical graduates in the near future, HA would be confronted by a more stringent financial situation and slimmer workforce while the demand for public hospital services would grow progressively, hence greater workload and stress on the frontline health carers. In order to maximise the service outcome and maintain the work-life balance and morale of a highly dedicated team of health carers, HA should strategically and prudently deploy its healthcare resources to pressurised areas with the gravest issues of prolonged work hours, having regard to the right incentive, equity and sustainability of different work reform initiatives. Considerations should be given to the varied experience and work reform outcomes in the pilot hospitals, such that resources could be deployed in priority to programmes which had greater potential for improving the system efficiency, enhancing the quality of patient care and safety, and optimising the workload of the healthcare workforce in public hospitals. On the other hand, HA was recommended to continue reconfiguring its hospital services, enhancing the service quality and improving the morale of its staff, so that the entire organization might tide over the crisis smoothly with the concerted efforts of all parties. Pragmatic modes of clinical operation should be encouraged while greater support should be given to boost multi-disciplinary collaboration, enhance

the roles of health carers in patient care and strengthen the system support to expedite patient management. All these would render a more cost-efficient and effective public healthcare system that would benefit patients, staff and the entire organization.

ENHANCED HONORARIUM SYSTEM

804 In November 2007, the Steering Committee recommended HA to explore a sound and appropriate honorarium system with a view to duly recognising doctors' excess work in providing dedicated healthcare services for patients in public hospitals, and to revamping the prevailing fixed-rate honorarium system which had been in force for over 20 years. The enhanced honorarium system should not only resemble the conventional fixed-rate two-tier honorarium system by taking a broad-brush approach to recognise doctors' excess work hours nominally, but also allow more flexibility to better address the variations of doctor work patterns in different call tiers, specialties and hospitals. HA foresaw the enhanced honorarium system as a tool to improve quality doctor hours for both service and training, and recommended the following principles in formulating its enhanced honorarium system:

a) The honorarium should serve as a token of recognition instead of an incentive for over-rostering or self-generating overwork for higher pay.

b) Doctors' excess work hours should be recognised financially but nominally.

c) Doctors should not be worse off under the enhanced honorarium system.

d) Sustainability and affordability should be considered.

805 Two options under the broad-brush nominal recognition system had been proposed, the first basing on doctors' average weekly work hours while the other on their frequency of standardised calls or shift per month, as illustrated below.

Fig. 8.1 – Enhanced honorarium based on doctors' average weekly work hours

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-follow/ 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. 8.2 – Enhanced honorarium based on doctors' standardised call / shift per month

Option 2 – Honorarium Based on Frequency of Standardised 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-follow/ Non-trainee	Higher Trainee	Specialist (Resident/MO)	SMO/AC	CON
1						
2						
3						
4						

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

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

806 Both options carried the features of prospective expectation of work hours or call frequencies / shifts rather than retrospective compensation for their actual hours worked. The tiers of honorarium were expanded so as to better differentiate the varying workload of doctors subject to the cap of 65 hours per week on average. It was expected that doctors possessing comparable levels of competence and working in similar call tiers, clinical specialties and hospital settings would share similar work patterns and draw a similar rate of monthly honorarium. This was in line with the "more pay for more work" principle and might address the inadequacy of the current 2-tier fixed-rate honorarium system in recognising doctors' excess work hours.

807 The Steering Committee was more in favour of the first option that was based on doctors' average weekly work hours for reason of simplicity and fairness. For an enhanced honorarium system based on doctors' standardised call frequency, HA needed to tackle the heterogeneity and complexity of their call systems in different clinical specialties and hospitals. Irregular hours of long and short calls were entailed and diverse nature of on-site and off-site calls were involved. This required immense work in aligning the call systems at different sites. Besides, there could be disputes over the calculation of the call / shift systems between the management and the frontline.

808 In the past two years of work reform implementation, there had not been any pronounced views and suggestions from the frontline as to how the enhanced honorarium system should be formulated. HA was therefore recommended to explore the matter further in order to address the disparity of pay in recognition of doctors' excess work. Moreover, for whichever option to adopt, HA was recommended to review doctors' work hour or call / shift frequency every three years so that flexibility would be maintained and the enhanced honorarium system would evolve with the changing mode of operation in different clinical specialties brought about by the work reform implementation.

809 On the other hand, HA might consider using the established Special Honorarium Scheme to recompense medical staff for their voluntary work in handling the anticipated surge in workload. Although its nature was different from the enhanced honorarium system that was targeted to nominally recognise doctors' excess hours of rostered duties, this Special honorarium should be welcomed by the frontline doctors in recognition of their contribution to ad hoc clinical activities.

THE STEERING COMMITTEE'S RECOMMENDATIONS

810 The Steering Committee recommended the following measures in relation to the targeted deployment of resources:

a) HA was recommended to prudently deploy its limited resources to pressurised areas, with due regard to equity, right incentive and sustainability of the work reform initiatives. Given a healthcare budget, coupled with the engulfing financial tsunami and the epidemic outbreak in the community, the demand for public healthcare services, hence service volume and workload, would definitely rise in the coming years. Resource utilization should therefore be prioritised for those programmes that had a greater potential for increasing the system efficiency, optimising workload, enhancing the quality of care and patient safety as well as improving staff morale. Meanwhile, HA was recommended to continually explore different ways to reconfigure its hospital services and rationalise its service provision for the ultimate benefits of patients and the society.

b) HA was recommended to develop a sound and appropriate honorarium system, with due regard to affordability and sustainability concerns, in order to financially recognise doctors' excess work hours in a broad-brush and nominal approach. In this connection, an enhanced honorarium system using doctors' average weekly work hours to differentiate bandings of doctors in different call tiers, specialties and hospital settings should serve the purpose while not incentivising them to over-roster or self-generate overwork for more pay. On the other hand, HA might consider supplementing the enhanced honorarium system with the established special honorarium scheme in order to recognise frontline doctors' contribution to ad hoc clinical activities.