

Hong Kong College of Health Service Executives

Newsletter Issue 2 2010/11



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Message from the President

Nearly all governments round the world are talking about health care reform. The Hong Kong SAR Government is no exception. Indeed just in the past two decades we have already witnessed four consultation papers put forward by different Health Secretaries, although none had successfully been implemented. Nevertheless the health care system of Hong Kong continues to thrive, especially the private sector in the recent few years. But the cry for urgent reform continues with the same tune: the highly subsidized public health care system is financially not sustainable if the existing financial model does not change.



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The problem is that people of Hong Kong, after seeing what happened in the past, do not believe that they need to pay more to the government in order to keep the public health care system continue working. So the latest Government Consultation Paper adopts a strategy that does not focus on ways of broadening financial source for the public health care. Instead it tries to sell to the people a private health care insurance scheme that is heavily regulated by the government, hoping that by establishing such a scheme the dependency on the public health care system can be reduced. The target participants are those with chronic health problems who are presently rejected by private insurance and thus rely heavily on the public system.

It has strong resemblance to the Australian system in which the government encourages people to have private health insurance as supplement to the Medicare system. How far the proposal will go still needs to be seen especially the success of the scheme depends very much on the willingness of the young and healthy to join so as to make the whole system financially attractive or acceptable. But for those executives working in the public sector an impact has already been felt: the brain drain from the public sector to the private sector has been exacerbated in the last two years. This has reached alarming level in some groups, such as nurses, radiographers and some specialists including radiologists and eye specialists.

The problem originates from the fact that most health care professionals require a long lead time for training, and as most of them are produced by tertiary academic institutes nowadays, the responsiveness of the system to change in demand for workforce is quite low. Also the expectation that when more people have private health care insurance, the use of public health care will be reduced leading to less demand for health care professionals has not been realized. This is probably related to the rapid aging of the population. So if the SAR Government expects her proposal to be accepted by the Hong Kong people while at the same time the public health care system can continue to work smoothly, this workforce issue must be addressed without any delay.

A comprehensive workforce plan which incorporates the factors related to the latest reform proposal should be drafted and implemented as soon as possible. We should not wait for the outcome of the reform proposal, as that will be too late and put the public health care system under great pressure. Otherwise the result is a weakened and risky public health care sector which will generate a lot of political stress to the Government in turn.

Dr MA Hok Cheung



onversation with Shane Solomon

On 9th September 2010, I had the opportunity to interview Mr. Shane Solomon, Chief Executive of the Hospital Authority who has recently resigned from the post and will be leaving Hong Kong to take up a new position with KMPG Health Care in Australia. Here is our conversation:

S: Shane — M: Margaret



M : Coming from Australia where we do share some similarities in our health care system, what do you think are the biggest difference between the 2 systems and if there are things that Australia can learn from HK, what would that be and conversely, what can HK learn from Australia?

S : I guess the thing that I find so different here in Hong Kong is that nurses are less assertive whilst in Australia; nurses are seen more as an integral part of the health care team and given a more trusted position. Perhaps this is partly due to the culture of Hong Kong where respect for doctors and the hierarchy are important. I am not saying that they don't respect doctors in Australia but nurses certainly have a bigger say in the system. The other area is primary care. In Australia, the Government supports primary care and most of Australia's primary care is affordable. You can see that most chronic care is managed in the primary care setting which is more sensible than having people visit many specialists. It makes more sense to have care integrated at one point. As care becomes fragmented, it gets more expensive and difficult for people. The third point about Australia's system which I think we value is the choice of doctors in the public system.

As for the things that Australia can learn from Hong Kong, I guess I can list electronic health record on top of the list. This centralized system leads to efficiency and we can use the system in so many ways, data mining to assess the quality of our services, clinical audits, etc. The other thing that strikes me is that clinical governance is so much better here in Hong Kong than in Australia. Here we have a consistent structure of involving the Chiefs of Services in all the COCs (Central Co-ordinating Committees) where the

information and decisions are from bottom up and there is much more engagement with the frontline. We are nowhere near that in Australia. The third point is the centralized support system, particularly the pharmacy and the procurement of medical supplies where we can get savings with the bulk contracts. This all ties back with the second point on clinical governance where you can get consensus so quickly with the COCs to agree on the drugs etc and then we get the procurement system to work out the bulk contracts

M : The HA is a very unique set up in Hong Kong. If we were to rewind the clock back to the early 80's and if you were to be in charge of writing the Scott Report, would you have recommended the setting up of the Hospital Authority.

S : I would certainly have recommended a separate Authority. The civil service makes rules for the whole Government machinery and makes rules for all the departments so it can't be specific to your needs. A modern health care system has to be flexible and can change quickly, so pulling health care out of the Government or keeping it at arms length is essential for health care to move ahead. Would I have recommended a Hospital Authority? Definitely no. Health care needs to be integrated and the more integrated the system, the better it is. It is difficult to have to cross boundaries especially when you have to deal with crisis situations and this is where I think we need to have a Health Authority and not just a Hospital Authority.

M : How do you see the health care system of HK evolving in the next ten to twenty years?

S : No dramatic change. Even if we double the number of hospital beds in the private sector,

M : We often say that health care reforms keep on reforming and that there is no end to it. Are you not tired of all this and how do you keep up your passion for what you do, especially when we are not making any progress?

M : I understand that you will be going back to Australia to head health care sector of KMPG Australia. What are the challenges there and what do you hope to achieve in your new post?

M : Do you see a bigger role for the private sector of Hong Kong in future and will this pose a challenge for HA?

M : Tell me Shane, why are you leaving HA and Hong Kong. People don't believe you that you are leaving because of your family. They suspect that there must be some other reasons?

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really enjoyed the work situation but I just find that I was becoming more and more obsessed with work, more self centred, and self absorbed. Together with a host of other complex family issues, I had to make a decision as to whether I want to continue with work at the centre or change the balance. As you know, my family has moved back to Australia and it has been pretty hard for me to leave them, and much as I enjoy my work mates, I don't think they are the same as the family. I guess there are lots of ways one can contribute and the important thing is that my effectiveness and ability to do this job depends on my personal happiness. So it does not matter to me whether I am the CE or not, and by the way, people who aspire to be CE are usually unhappy, tired or stressed. There is this book, I can't remember what the title is, something like "So You Want To Be the CE", well in that book, this guy was being asked what is the most important day of his work life and his answer was the day he became the CE and you know what, this is not the answer. The answer should be the day that I have achieved something important not the day that you become CE. This whole business of personal glory and power does not make much sense. Well I guess I am undergoing mid life CE crisis to be talking like this but why do you want to be CE, if it's just about reaching the position, you won't actually be a good CE.

M : Shane, so far we have touched on the serious stuff. Any funny stories that you will remember when you leave Hong Kong?

S : Well you must have heard of this before. The ones I find really strange and unusual (perhaps, not funny) are the mainland women waiting in car parks waiting for their time to be up to rush to A&E to deliver their babies and the "Dracula" drinking blood from the test-tube in one of our hospitals.

M : Tell me Shane, what is the most difficult moment in your job as CE of HA

S : I guess I would say that the demonstration by the doctors in QEH, that was the most difficult moment, when our Chairman was being "beaten" up by the doctors and you know what, the most difficult thing was I know they were

right in their demands but we had no money to solve it and no idea how to solve it. That was the most difficult moment. The other one must be the restructuring of HAHO- you are talking about people's jobs and redundancies, that was very sensitive and very difficult to do.

M : Any unfinished business?

S : Oh yes, the list will be long but electronic health record , waiting times still too long, electric beds, filmless radiology, mental health, building a new generation of nurses, new pharmacy system, etc

M : This is not a eulogy but after you leave, how would you like people in HA or Hong Kong to remember you?

S : I guess I would like them to remember me as the guy who listens, tries to understand their issues and tries to do something, not always successful but I try.

M : Shane, you may not know this but when we heard you were coming to head up HA, we immediately searched the net to see if we can find anything about you. You know what I found. Someone posted this comment:

"Good news, HK HA is getting my former boss, Shane Solomon as its CE. He is a good man and knows what he is doing. He is very ethical and honest and extremely competent at running health systems."

S : Thank you, that was very nice. I certainly did not know about this.

M : Thank you Shane for spending time with me and all the best wishes from the Hong Kong College of Health Service Executives. We have a small souvenir for you which we hope will help you remember your affair with Hong Kong.

(Margaret presents a book " Hong Kong- An Affair To Remember" to Shane Solomon)

S : Thank you Margaret.

Ms Margaret TAY



2010 Annual Conference cum Annual General Meeting

10th July 2010 Langham Place Hotel, Kowloon



2010 Annual Conference
cum Annual General Meeting

Fellowship Conferment Ceremony



Our New Fellows

Congratulations to the following who passed the recent Fellowship examination and were conferred as fellows of the College at the AGM cum fellowship conferment ceremony

<i>Sham So Yuen, Alice</i>	<i>Lee Lai Yin, Irene</i>	<i>Chan Chi Keung, Steve</i>
<i>Ng Sin Yee, Anita</i>	<i>Yu Dick Fung, Josephine</i>	<i>Fung Yuk Kuen, Sylvia</i>
<i>Wong King Chi, Ellen</i>	<i>Cheng Sau Kong, Kelvin</i>	<i>Siu Wing Sze, Venus</i>
<i>Ziea Tat Chi, Eric</i>	<i>Lee Ha Yun, Libby</i>	
<i>Lee Wai Man, Fion</i>	<i>Yu Wai Ling, Linda</i>	



Council members with speakers



Fellows with examiner:

2nd row (from left): Anita Ng, Alice Sham, Libby Lee, Venus Siu, Ellen Wong, Linda Yu,

1st row (from left): Eric Ziea, Josephine Yu, Sylvia Fung, Geoffrey, Irene Lee, Steve Chan, Kelvin Cheng



Sleepless in Seattle

You may wonder why I was sleepless in Seattle. Well, I was fortunate to be given the opportunity to join the Seattle Study tour for senior clinicians and managers in health and social care organized by the King's Fund of the United Kingdom from 12th to 17th September 2010. By travelling more than 17 hours to reach the destination, and with the change in time zone, I had to put up with many sleepless nights in Seattle. But my sufferings were worth the trouble for I saw and experienced some very innovative and exciting approaches in the diverse health care industry of the United States.

Our study tour starts in Seattle, a pioneering city famous for its innovation and entrepreneurship and also known for its beautiful Puget Sound, temperate rainforests and Mt Rainier as well as home of Boeing, Microsoft and Starbucks. We visited five different health care organizations including the Veterans Administration, Harbourview Medical Centre, Virginia Mason Medical Centre, Everett Clinic and Group Health. We also had the exclusive opportunity to visit Microsoft and gained some insights into what this company is doing in the health care sector. We were joined by a bunch of very enthusiastic health care managers from the United Kingdom and throughout the five day visit, had the opportunity to also learn from this group on the recent health care reforms taking place in UK and of course, spiced with a huge dose of British humour along the way.

Our visit begins with Virginia Mason Medical centre, an award winning private not for profit organization offering a network of primary and specialty care clinics throughout the Puget Sound region. Virginia Mason is one of the first organizations in the world to adapt the Toyota Production System to health care and they call it the Virginia Mason Production System (VMPS) which is a management method that seeks to continuously improve how work is done so that there are zero defects and waste is eliminated from the system. We were impressed by how the organization has embraced this management system and embedded this in its organization culture.



The Everett Clinic
For the whole you.

Group Health

HealtheVet

Microsoft

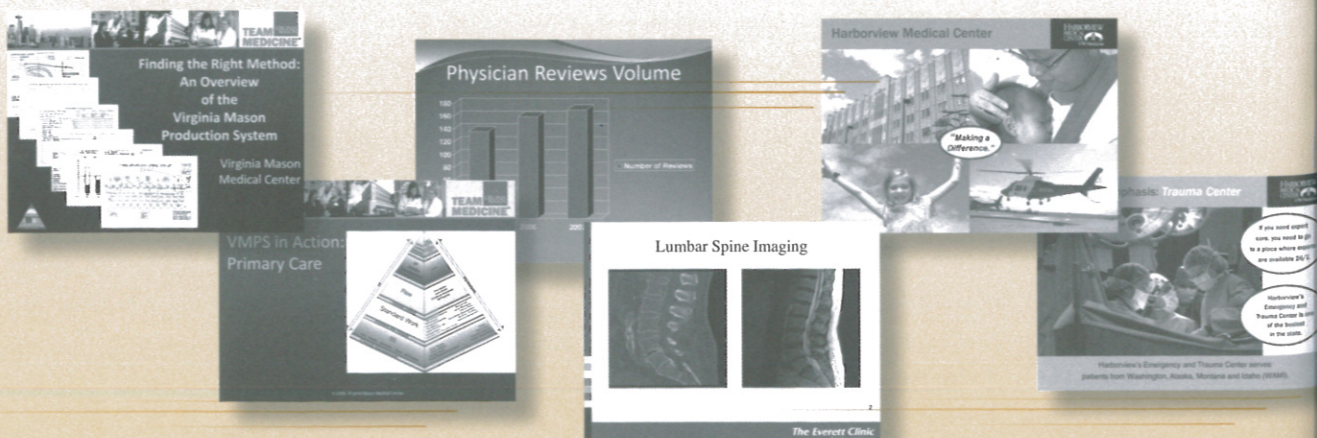
We saw all the foundational elements of LEAN management in this organization. In the hospital ward, there were geographic assignments, huddles every shift, in room handoffs, RN: Personal Care Technician paired up, hourly rounds, documentation near the patient with Computers on Wheels (COWs), daily leader rounds, and an absolute obsession with standard work, metrics and measurements. It was truly amazing how a health care organization has adopted the production method used in the car manufacturing industry and applied it in the health care industry to drive efficiency and costs down. Their relentless war on waste was inspiring and the fact that their senior leaders practice what they preach with single-mindedness for the past ten years, to the point of being religious, is perhaps their recipe for success. The visit to Virginia Mason also included a short visit to an out-patient clinic which left a deep impression on me. The idea of "ON stage, Off stage" adopted from Disney was applied to the clinic setting. Patients checked themselves into their clinic and there was no waiting area. Staff work behind the scene (Off-stage) and there was use of visual aids to make sure that everything flows. The whole environment was quiet and serene, very unlike the chaotic, noisy and crowded waiting rooms that we see in many of our hospitals in Hong Kong.

The visit to the Everett Clinic was next. This is a locally owned physician group practice with nearly 300 physicians and more than 1,500 staff. They provide primary and specialist clinics and also offer advanced imaging center. I must say that I was not particularly impressed with this setting. The only thing that left an impression on me was the way they used physician scorecard to measure the performance of their doctors on all aspects of their work, including patient satisfaction, peer review, patient complaints, productivity and quality measures. It is a sophisticated system and incorporates a lot of measurement. As physician credentialing is a hot topic, this setting certainly seems to have put a lot of effort into this aspect of their work. Another interesting aspect of their work is the close partnership between physicians who act as the facility medical director and the clinical practice manager who take care of the staff and facility issues.

Harbourview Medical Centre is a teaching hospital and the public hospital of King County. It is the only level I adult and paediatric trauma center and regional burn centre for the states of Washington, Alaska, Montana and Idaho. Harbourview provides leading-edge teaching, research and clinical care for all patients. The hospital is owned by King County and governed by county appointed board of trustees and managed by the University of Washington and part of the UW medicine system of care. It is interesting to note that apart from being a cutting edge trauma center, this hospital devotes a large part of its resources to charity care and serving the underprivileged groups. They have a list of mission

population which the hospital has prioritized to treat. Hence they run services for substance abusers, indigents, non English speaking population, victims of domestic violence, victims of sexual assault, prisoners and persons with mental disorders. We met a primary care doctor who has been with the hospital for a long time and she runs a clinic for the homeless in downtown Seattle, trying her best to connect with these folks and to provide the best care that she can. In fact, we were told that Harbourview's commitment to helping the underprivileged has been the magnetic force in attracting highly qualified doctors from all over the country to work in this hospital as they subscribe to the hospital's mission of looking after the special groups. The hospital also runs a very impressive interpreter services catering to the different languages and dialects of the different population groups that they serve. They also have outreach services for minority ethnic groups and have also developed a web site providing health care resources in different languages. For the mentally ill, the hospital has gone beyond providing medical care. They started the 1811 Eastlake project which is basically a housing project for alcoholics. By providing housing with support and creating a stable environment, this project has been able to demonstrate some measure of success.

The next site is Group Health. This is a non-profit health care system that provides both health care and health insurance coverage, like the well known Kaiser Permanente. It is a consumer governed organization which provides coverage to more than 600,000 residents in the state. At this site, we were



given a tour of how they apply LEAN at the different levels of the organization. We saw how broad strategic targets were broken down into different levels and how the different levels will measure and monitor these to create alignment all the way up to the top. The CEO factor or visibility of top management at walkabouts or GEMBA was emphasized. Designing standard work, use of dashboards, A3 gap analysis and linked checking were some of the LEAN tools that were visibly displayed all over this organization. They also told us about a Medical Home project which is essentially a primary care project. By creating standard work around access and the use of secured messaging, they were able to demonstrate some substantial savings and to create better and more value for patients. It was interesting to note that each of their primary care doctor had a target of sending or responding to at least a certain number of secured messages from their patients and they were all monitored on this. Everything was standardized. Each appointment session was standardized to 20 minute session and physicians were incentivized on indicators such as face to face visits, number of secured messages and number of care plans that they create for patients. Amazing!

Then to Veterans Affairs Puget Sound Health Care System, part of the integrated Veterans Administration Network that takes care of veterans. The facility looks more like our public hospitals and less like those we saw earlier on. As the VA is a huge organization, they have leveraged on this to create electronic medical record in the whole system to drive quality of care.

The final day of the visit was spent in Microsoft where we held discussions with their executives on talent management and had the fantastic opportunity to look at their Microsoft home tour, a futuristic home using advanced consumer technology. At Microsoft, we also had the opportunity to learn the new term "in the cloud" computing and also how this has been applied in various aspects of health care. It was an eye opener as to how technology can be applied to health care and I guess as health care executives, we should really be open to a whole range of technologies that are already available today and see how we can apply to healthcare in order to drive quality and reduce costs.

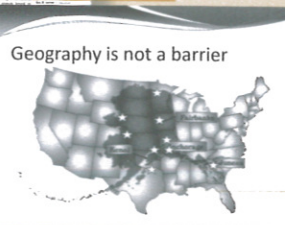
So after spending six sleepless nights in Seattle, I finally made my way back to Hong Kong. I nearly missed my connecting flight in San Francisco and of course, when I touched down in Hong Kong, my luggage was missing, adding to another sleepless night in Hong Kong! So with another sleepless night, I decided to write this article for the College and by the way, here is my final take home message: when you cannot sleep, find time and space for some creative thinking, reflections and write them down and most of all, share these with your fellows of the College.

Ms Margaret TAY



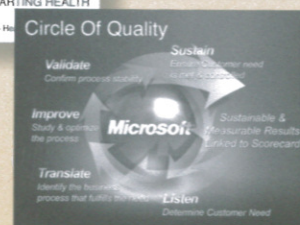
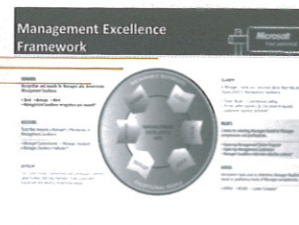
DOWNTOWN PROGRAMS

Harborview Medical Center
AACS
2010



RE-CHARTING HEALTH

Director - Health



Australian Study Tour - Journey to Perth and the National Congress of Australasian College of Health Service Management

11 – 16 July 2010

The Perth Study Tour cum the National Congress of Australasian College of Health Service Management (ACHSM) organized by Hong Kong College of Health Service Executives (HKCHSE) set off for Perth, Australia on 11 July 2010 evening. There are 30 members (26 college members and 4 family members) registered under HKCHSE Perth Study Tour which is the largest group in recent years.

Dr H C Ma, Head of Delegation and Dr S H Liu, Study Tour Leader met the members of study tour at 9pm on 11 July 2010. After an overnight flight, the group arrived Perth at 7:20am on 12 July 2010. The study group was welcomed by a light shower upon arrival. Greeted by a local guide, the group commenced the Perth city tour of Kings Park, Lotterywest Walkway, Barrack's Arch and Parliament House, The Bell Tower, Burswood Park, Lake Monger and Northbridge. Fortunately, the weather was fine during the visit. The study group had chances to visit the nice and attractive part of Perth. After a joyful trip, the group returned to the hotel.

On 13 July 2010, the study group attended a forum organized by ACHSM. Associate Professor John P. Rasa delivered a talk on the Overview of Australian Health Care System. The study group was updated with the overview, latest development on health reform and future challenges of Australian health care system. After the thorough and enlightening lecture, we headed towards the Swan Valley tour. Under the sunny weather with light breezes, we spent a leisure day in Swan Valley. We had a wine tasting and brought a good collection of wines. Then, we visited noughats factory as well as chocolate factory where we brought back a handful





of local made products. Besides, we have visited Caversham Wildlife Park and enjoyed Tumbulgun Farm show where we could have a close contact with kangaroos, wombats, etc. Koala was the star of the park which most of us were fancy of. After that, we joined the Fellows Networking Drinks and Dinner at Esplanade Hotel Fremantle which we received a warm welcome by ACHSM.



Extensive Achievement assessments on nine out of the fourteen mandatory criteria. These covered clinical and non-clinical areas, with acclamation in particular for the infection control, continuous quality improvement and risk management systems; the way hospital involved patients in care planning; and their management of patient feedbacks and complaints. This external audit result confirmed the hospital ongoing commitment to, and achievement in, clinical quality and patient safety. We learnt much on how to make use of accreditation as a formal process to assist in the delivery of safe, high quality health care based on standards and processes devised and developed by health care professionals for health care services.

On 14 July 2010, we divided into two groups for Perth hospital visit. One group visited St John of God Murdoch. St John of God Hospital Murdoch is part of St John of God Health Care Inc, a not-for-profit organisation dedicated to furthering the values and healing mission of Jesus Christ. Established in 1994 to provide comprehensive, quality health services for patients in Perth's southern suburbs, St John of God Hospital Murdoch is now one of Australia's leading private health campuses. We received warm welcomed from the hospital and the executives shared with us the road to accreditation by Australian Council. We have a guided tour of the major facilities of the hospital. Following a regular periodic review by the Australian Council on Healthcare Standards in 2009, St John of God Hospital Murdoch gained





Another group visited Fiona Stanley Hospital for their development project. Construction of Fiona Stanley Hospital is underway with the first concrete poured for the main hospital building in December 2009. The hospital has a project budget of A\$1.76 billion and includes 643 beds. In addition, the Australian Government has provided A\$255.7 million in funding for a 140-bed State rehabilitation service. When it opens in 2014, the hospital will be the main tertiary health facility in the south metropolitan area, offering services to communities in Perth's southern suburbs and across the State. In December 2009, model ward was constructed to give key stakeholders an opportunity to provide feedback about the prospective fixtures, fittings, furniture and other medical equipment. The feedbacks gathered from the room viewings are now being incorporated into hospital planning.

After the hospital visit, the group joined the ACHSM 2010 National Congress Opening in the afternoon. The theme of the conference is "Sailing the Tides of Turbulence," acknowledging that internationally we were experiencing unprecedented upheaval in our lives and work - socially, economically, structurally, financially, and emotionally. Managing the delivery of health services and health facility buildings is no difference. The aim of this Congress is to present new thoughts on the main challenges faced by health managers and the built environment professionals with whom they interact. More than 400 attendances including health service managers, health facility planners, architects, project managers, building contractors and others.

In the evening, there came the greatest time for Hong Kong fellows as there was a Fellowship Conferment Ceremony. A good number of fellows travelled all the way to Perth were looking forward to this memorable moment. You can envisage the excitement and joyful moment as shown in the photos.





On 15 July 2010, the group attended the conference which had excellent speakers presented across four streams – Effective Leadership, Workforce, Quality Safety and Risk, and Health Facility Planning and Design. In the evening, the group joined the Congress Dinner. There was a costume competition and the theme was pirate. You can see that some of us dressed up for the competition! There was a dancing session after the Congress Dinner and the group members have danced energetically.

On 16 July 2010, the group joined the closing session of National Congress in the morning and we



have managed to visit the last hospital on the study tour program - Joondalup Health Campus which we were greeted warmly by the hospital. We were showed around in the Campus to learn the journey of development. The Joondalup Health Campus dedicated to providing high quality health care to the residents of Perth's northern suburbs. The 379-bed campus, which includes both public and private hospital facilities plus a specialist medical centre with specialists and diagnostic services, meets the health care needs of the community.

The Joondalup Health Campus planned a A\$320 million redevelopment of their facilities to enable them to continue to accommodate local needs. Joondalup Health Campus will have increased in size to a 541-bed hospital with 456 public and 85 private beds. The Emergency Department, Operating Suite, Critical Care Unit, Day Procedure Unit and support areas will have also significantly increased in size. Construction will take approximately three years and earthworks have already begun on-site.



After an inspiring hospital visit, the study tour program also came to an end. The group set off to the airport and took 22:15 flight to Hong Kong. With such fruitful and eye-opening Perth Study Group program, I would like to express my gratitude to Dr H C Ma, Dr S H Liu, Tammy So as well as many other Council Members. I am eagerly looking forward to the coming ACHSM National Congress 2011 which will take place in New Zealand in 24-26 August 2011. Do mark your diary if you would like to join this exciting event in coming year!

Dr Steve CHAN Chi-keung



Clinical Governance, Using Hospital Authority as an Example

The concept of clinical governance was widely applied in 1995 after the Bristol Babies Scandal occurred in the same year in the United Kingdom (UK). This scandal was the case of longest ever inquiry by the General Medical Council in the UK. It was also set to be the longest-running and widest-ranging investigation into medical standards in the UK since the National Health Service (NHS) was founded in 1948. It sets the precedence of holding the Hospital Management accountable for substandard clinical care. The hearing finished in 1999 and both the Department Head of Surgery and the Hospital Chief Executive were banned from practicing medicine. The operating surgeon was found guilty of serious professional misconduct. Since then the concept of clinical governance was cultivated in the NHS and many health care organizations.

Clinical governance is used to describe a systematic approach to maintain and improve quality of patient care within a health care institution. It holds the healthcare organization accountable for continually monitoring and improving the quality of health care and services as well as safeguarding high standards of care and services by creating an environment in which excellence in clinical care will flourish.

The clinical governance begins at the highest, the national level. The evolution of patient safety as a health policy issue arose from the release of a number of seminar reports internationally, particularly the Quality in Australian Healthcare Study (1995) and the To Err is Human (2000) from the Institute of Medicine (IOM) in the United States.

Good governance also requires effective leadership throughout the organization, including the Board, Chair and non-executive directors, chief executive and executive directors, managers, clinicians and administrative staff. Clinical governance mandates a designated transparent responsibility at Board level and the organization must prepare an annual review of the quality of care and its maintenance.

In the United Kingdom, clinical governance was first mentioned in British Health Policy in 1997. In Scotland, it was introduced in the 1997 White Paper. In Ireland, a Commission on Patient Safety and Quality Assurance was set up in 2007 by the Minister for Health and Children. It aims to provide

recommendations for a framework of patient safety and quality to ensure clinical governance.

Clinical governance is an umbrella term which encompasses several key elements and themes, all of which, when effective, combine to support and foster a drive for patient safety and quality improvement. These themes, which are essential for all health care organizations and individuals to develop in pursuit of clinical excellence, include quality improvements and maintenance, professional accountability, creating and maintaining a safe environment for patients and staff, along with establishing an honest and open culture that encourages and responds to staff and public opinion.

In Hong Kong, the healthcare is provided by both the Hospital Authority (HA) and the private sector. There is a fall short of national policy on patient safety and quality. The clinical governance does not come from the highest level; rather depends on individual institution.

In HA, a restructuring was performed in 2007. Under the new organizational structure, the Quality and Safety Division oversees the quality and safety issues in the organization. These include incident reporting, risk management, quality assurance program like accreditation, clinical effectiveness like shortening of waiting time and waiting list, technology assessment, complaint management, clinical ethics and clinical audits. The Division had regular reported to the HA Board.

The Department of Health is responsible for the registration, under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap.165), and the direct reporting line of all the private hospitals in Hong Kong concerning medical incidents. Other quality issues like audits, effectiveness, technology assessment, and ethics are not addressed.

Whether there should be a standardized framework for patient safety and quality in both the private and public sectors remains the most debatable issue among the Legislators.

Dr. Libby HY LEE

Evidence Based Approach in Health Service Planning

Good health is a condition of life that most people enjoy and concern about it. People have a tendency to take good health for granted, and they assume that the system of healthcare service delivery will respond to their needs timely and effectively.

Although all healthcare systems worldwide have grown and changed a great deal in the past several decades, the response of the healthcare service delivery to what people needs are not always working as what people are thinking of. In fact, there are numerous of complex factors that could lead the system and its component parts under a great pressure, and the growth and change of services might not be necessarily for the good.

There is increasingly recognition of the importance of health services management in recent decades. In the past, health services were limited primarily to doctors and hospital inpatient services. Nowadays, health services must be considered in much broader terms such as primary, secondary and tertiary care, and multi-disciplinary approach etc. Therefore, how to manage health services more effectively and efficiently in delivery health services in keeping with the constraints and opportunities of the economic and political environment is a state-of-art.

In order to help a healthcare manager to make a right choice, there is a growing interest in promoting the evidence based healthcare practice. Evidence based practice refers to a decision making process which integrates the best available research, clinical expertise, and client characteristics to provide a cost-effective and high quality of healthcare.

Setting the right price for a health service is one of the hardest things for the healthcare manager. In the majority of cases, the pricing decisions are made without profound understanding of the likely response of the patients. They do not conduct the pricing research and as a result do not have a serious pricing strategy in a marketing sense. In fact, the perception of the service by patients is the cornerstone to successful pricing.

Numerous methods have been used to obtain the views of consumers. Economic techniques for eliciting public preferences all include the notion of sacrifice or trading. Such techniques are based on the assumption that something is only of value if an individual is willing to give something up for it. Given the limited budget in healthcare, devoting more resources to improve one aspect of a service means taking resources away from another aspect, that is, there is a sacrifice or benefit or an opportunity cost.

Willingness to pay generally refers to the value of good to a person as what they are willing to pay, sacrifice or exchange for it. Willingness to pay is the maximum monetary amount that an individual would pay to obtain a good. It can take account of non-health outcomes and process attributes. There are several methods to measures willingness to pay. Customer survey is one of the techniques used to elicit patient and public preferences.

Taking cataract as an example, cataract is a non-fatal condition but it can cause a variety of morbidities such as fall accidents. The average waiting time for the cataract surgery in public sector in Hong Kong is approximately 35 months. Yet, these people have already on the surgical list indicating that they are needed for surgery. A study done by myself was to demonstrate the use of willingness to pay in relation to the health service planning. This study, published in a peer-reviewed journal, aims to characterize willingness to pay for private operations and preferred waiting time among patients awaiting cataract surgery in Hong Kong. A cross-sectional survey of 460 subjects randomly selected from cataract surgical waiting lists in Hong Kong underwent telephone interview based on a questionnaire. It was found that majority of cataract patients in Hong Kong would be willing to pay any amount for surgery in return for less waiting time. Patients were willing to pay nearly twice the amount the public system is currently charged in order to reduce waiting time.

The preoccupation with productivity and quality that has dominated health service management in last century has not necessarily led to the development of evidence based policies, nor to the implementation of knowledge derived from research for the improvement of the effectiveness, safety, acceptability and cost-effectiveness of healthcare. There is now general appreciation that decision made about health services and clinical practice must be based on evidence to a much greater degree than they have been in the past such that knowledge derived from research can be used to improve the health of patients and public.

Enabling health professionals to evaluate research evidence and to use it in daily practice is also important part of lifelong professional development. This requires not only changes in educational programmes, but also a realignment of institutions so that management structures support changes in knowledge and the implementation of changes in procedures.

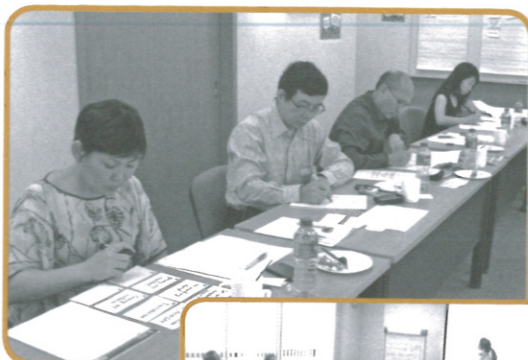
Successful bridging of the barriers from evidence to decision making will not ensure that the health service delivery will be the most cost-effective as there are many other factors that might prevail, notably in these days underfunding of health services and misdistribution of resources. Nevertheless, incorporating current best evidence into the management decision promises to decrease the traditional delay between evidence generation and applications, and to increase the proportion of patients from whom current best service is offered. Quick access to accurate summaries of best evidence is rapidly improving at present. Means for creating evidence based management policy and applying this policy appropriately are under development, with this final frontier being advanced by current health services and information research.

Dr. Frank CHAN

Past Events ►

Strategic Planning Workshop

A half day strategic planning workshop was conducted in mid September 2010. Council members put their brains together to re-visit the vision and mission of the College.



The New Vision

- To excel and innovate in health leadership and management effectiveness

The New Mission

- To link up and equip health leaders for success



New Core Values

- Ethics, leadership, Collaboration and Social Responsibility

New Operational Focus

- Expanding membership base
- Establishing our professional identity
- Developing structured fellowship training program

Coming Up Soon! ►

Date & Time	Venue	Speaker	Topic
8 Nov 2010 6.30 – 8.00 PM	Seminar Room 1, M/F, HA Building	Ms Pauline Ng Secretary General of Legislative Council	Preparing for LegCo Meetings, a No-kidding Job
19 Nov 2010 6.00 – 7.30 PM	Room 205S, 2/F, HA Building	Mr Stuart Francis Specialist Advisor to Health and the Public Sector	Experience on primary healthcare reform in New Zealand and the Challenges ahead
24 Nov 2010 6.30 – 8.00 PM	Room 205S, 2/F, HA Building	Professor Gabriel Leung, JP Under Secretary for Food & Health	Health Insurance



[illegible]

HKID No.:

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Professional Qualification : _____

Qualification in Health Care Management : _____

Work Position Held : _____

Place of Work : _____

(Organization / Institution)

[illegible]

Daytime Contact Phone No. : (off) _____ (mobile) _____

Fax No.: _____ Email : _____

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Please send this application with cheque payable to "Hong Kong College of Health Service Executives Ltd." to P.O. Box No. 70875, Kowloon Central Post Office, Hong Kong.

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