# LCQ6: Cataract surgeries

Following is a question by Dr the Hon Dennis Lam and a reply by the Secretary for Health, Professor Lo Chung-mau, in the Legislative Council today (November 20):

Question:

It is learnt that at present, about 69 000 elderly persons in Hong Kong are waiting for cataract surgeries in public hospitals, and taking the Kowloon West Cluster and the New Territories West Cluster of the Hospital Authority as examples, the waiting times for such surgeries are as long as 4.3 years and 4.6 years respectively. There are views that while the Government has announced in the 2024 Policy Address that it will increase the service capacity of cataract surgeries in the public healthcare services by at least 20 per cent, the number of patients who need to undergo such surgeries will only increase given Hong Kong's ageing population, and so there is a need to reduce the waiting time of patients through various channels in the long run. In this connection, will the Government inform this Council:

(1) whether it has estimated how much waiting time can be reduced for patients after increasing the service capacity of cataract surgeries; whether the Government has set an indicator for this;

(2) as there are views pointing out that the Cataract Surgeries Programme (CSP) under the Pilot Public-Private Partnership Programmes is a great success, whether the Government will consider extending the scope of application of the Elderly Health Care Vouchers to cover CSP, thereby enhancing the financial capability of elderly patients for undergoing cataract surgeries and increasing the attractiveness of CSP; and

(3) as it is learnt that at present, patients need to be on the Hospital Authority's cataract surgery waiting list for 18 months or more before they are eligible to be invited to participate in CSP, whether the Government will consider relaxing such threshold, so as to reduce the number of patients waiting for cataract surgeries in public hospitals?

Reply:

President,

In consultation with the Hospital Authority (HA), the reply to the question raised by Dr the Hon Dennis Lam is as follows:

(1) The waiting time for cataract surgeries in public hospitals has been persistently on the rise in view of (i) the ageing population, (ii) the wastage of healthcare manpower from brain drain to the private sector, and (iii) the backlog of surgeries due to the three-year COVID-19 epidemic.

At present, there are about 360 ophthalmic specialists in Hong Kong, but

only 79 of them are serving in the HA, being also responsible for training 114 young specialist trainees. To ensure that patients with urgent needs in public hospitals are accorded priority for treatment, the HA has implemented a triage arrangement whereby cataract patients are screened by ophthalmologists. Priority 1 refers to urgent cases, such as those with mature cataract and more significant visual impairment, where the HA aims to perform surgeries within two months, and the actual median waiting time in the past year was one month. For Priority 2, such as those with occupational needs, the target is to perform surgeries within 12 months and the actual median waiting time was seven months. In other words, the targets for both categories of cases were met. That said, the rest are non-priority routine cases. At present, there are about 69 700 patients waiting for cataract surgeries in public hospitals in Hong Kong, with the number of Priority 1, Priority 2 and Routine cases being about 170, 6 000 and 63 500 respectively. The overall actual median waiting time for cataract surgeries was 14 months, while the 90th percentile, i.e. the longest waiting time, was 38 months. As for the Kowloon West and New Territories West Clusters mentioned by Dr the Hon Dennis Lam in the question, the quoted waiting time figures are in fact the 90th percentile. The median waiting time for both clusters is 14 months.

The median waiting time of 14 months with that for 10 per cent of the patients exceeding more than three years is not ideal. The Government has noted the public's concern over the excessively long waiting time for public ophthalmological services, especially cataract surgeries. Coupled with the ageing population, it is expected that the demand for cataract surgeries will continue to rise. In this connection, the HA must take the lead in collaborating with the ophthalmic sector to adopt reform measures, explore the use of resources and model in an innovative manner and adopt a multi-pronged approach to increase the capacity for cataract surgeries, including:

(i) Consolidating the current scheduling of cataract surgeries, allocating dedicated sessions for surgeries and setting the target of average number of surgeries to be completed for each session;

(ii) Preparing to set up high-flow cataract surgery centres to build up teams and optimise the workflow, and the plan is expected to be rolled out in the first quarter of 2025;

(iii) Continuing to strengthen manpower for ophthalmic services, including enhancing recruitment and training of local graduates, re-hiring retired staff and admitting non-locally trained doctors and part-time staff. The HA also makes use of the Special Honorarium Scheme to provide additional service sessions; and

(iv) Continuing to implement the Cataract Surgeries Programme (CSP) based on the public-private partnership (PPP) model to provide patients with an additional option.

The Chief Executive announced in the Policy Address 2024 the increase of the service capacity for cataract surgeries by at least 20 per cent, i.e. increasing the capacity of cataract surgeries by at least 5 000 additional cases in 2025-26. Taking into account the ongoing surging demand and based on

the projection of relevant figures, the average waiting time for general booking of cataract surgeries is expected to reduce by about 10 months after five years.

(2) The Government launched the Elderly Health Care Voucher Scheme (EHVS) in 2009 to encourage elderly persons to receive prevention-oriented primary healthcare services at private healthcare institutions. EHCVs are not applicable to secondary/tertiary healthcare services such as in-patient services or surgeries. The Primary Healthcare Blueprint also states that resources allocated to the EHVS should be optimised for effectively achieving the objective of promoting primary healthcare.

Cataract surgeries subsidised under the CSP are secondary healthcare services. The HA provides a fixed subsidy of $8,000 for each participating patient to receive surgeries at private healthcare institutions, and an out-of-pocket co-payment of up to $8,000 needs to be borne by the patients. In 2023-24, a total of 6 036 patients participated in the programme, and the actual expenditure of the subsidy borne by the HA alone was close to $50 million. Allowing settlement of the relevant co-payment by EHCVs will be inconsistent with the intent of EHCVs and PPP programmes and will at the same time lead to duplication of subsidies. The Government has no plan to make any change to the arrangement.

(3) The CSP invites routine case patients on the HA's cataract surgery waiting list who are suitable for local anesthetic procedures, with priority given to those with longer waiting time. At present, the waiting time for patients invited have been reduced to 14 months or more. The waiting time of patients under the programme will be reviewed in a timely manner.

The HA's PPP programmes give patients with relatively higher affordability a choice to receive services at private healthcare institutions through the co-payment model. This will help alleviate pressure on public healthcare institutions while making better use of the excess service capacity in the private sector. When exploring the expansion of the existing PPP programmes or introduction of new ones, the Government needs to carefully consider the relevant healthcare policies and the principles of strategic procurement of services as well as various factors including the ever-evolving service demands, patients' preferences and affordability, potential risks and quality of the healthcare services, the service capacity and adaptability of the private market, whether it would exacerbate the wastage of healthcare manpower in the public sector and drive up private medical fees and charges so as to avoid bringing about the opposite effects.