LC Paper No. CB(2)661/04-05(01)

For discussion on
20 January 2005

Legislative Council Panel on Health Services

Policy Initiatives of Health, Welfare and Food Bureau (HWFB)

Purpose

The 2005 Policy Agenda just issued lists the Government's new and on-going initiatives over the next two and a half years. This paper elaborates on the initiatives affecting the HWFB and gives an account on the position reached on initiatives relating to health services covered in the 2004 Policy Agenda.

2005 Policy Agenda

2. Our mission is to enhance the well being of every member of the community to build a healthy and caring society. We seek to ensure quality, equitable, efficient, cost–effective and accessible health systems and to organize the infrastructure for coordinated health care delivery through an interface of public and private systems. With continued globalization, the challenges posed by new and emerging infectious diseases and an aging population, we need to seek continuous improvements and enhancements to our health care system.

New Initiatives

3. Our new initiatives in respect of health are detailed below.

Strengthening the work of the Centre for Health Protection and Building up surge capacity in dealing with infectious diseases

4. In 2004, in relation to infectious diseases control, we have undertaken to enhance our preparedness against the outbreak of infectious

diseases[1], set up the Centre for Health Protection and conduct research relating to infectious diseases. The progress of these initiatives are Annexed.

5. With increasing globalization, there is continuing threat of new and emerging infections. We cannot afford to spare any efforts in enhancing our preparedness. In 2005, our focus will be on two fronts. First, we will continue to strengthen our hardware in terms of control infrastructure, information exchange, notification arrangements and isolation facilities. Secondly, we will enhance epidemiology training. The Centre for Health Protection (CHP) is developing a two-year field epidemiology training programme (FETP) to strengthen specialized epidemiological expertise and surge capacity in dealing with infectious diseases. The programme will become fully operational in mid-2005 and provide training for CHP professionals and others with an interest in communicable disease epidemiology including professionals in the Hospital Authority and private doctors. The CHP will also organize training programmes for paramedical personnel including those working in the Auxiliary Medical Service and the Civil Aid Service so as to build a competent surge capacity for crisis situations. Furthermore, CHP will seek to develop training links with other professional and academic organizations in Hong Kong, and establish links with training programmes overseas.

Comprehensive Review of the Quarantine and Prevention of Disease Ordinance (QPDO)

6. The current QPDO was enacted in the 1930s. Although the Ordinance has proven to be a sufficient instrument to enable effective implementation of disease control and prevention measures to tackle infectious diseases with the many amendments made throughout the years, some of the provisions have become outdated. In view of the development of the prevention of international spread of diseases and the overall infectious disease control strategies and mechanism in Hong Kong, we consider it timely to undertake a major revamp of the

---

[1] This initiative includes 4 elements : (i) development of a major infectious disease outbreak control plan; (ii) development of regular data reporting systems and collaboration on controlling infectious diseases within the Pearl River Delta region; (iii) building up hospital surge capacity and (iv) engaging all sectors of the community in infectious disease prevention and surveillance by co-ordinating preventive work across all sectors, paying special attention to vulnerable populations and involving the community in health promotion activities and health campaigns.

Ordinance. The scope of the exercise will cover the adequacy of the existing legal powers in the light of –

(a) operational experience;
(b) the development in international best practices; and
(c) the compatibility of the provisions with the development of the overall infrastructure of combating communicable diseases in Hong Kong, in particular taking into account the establishment of the Centre for Health Protection.

We plan to brief the Panel on Health Services of the Legislative Council on our broad thinking on the areas for changes in mid-2005.

Establish a Statutory Specialist Register for Dentists

7. We will seek to introduce legislative amendments to the Dentist Registration Ordinance to provide for the establishment of a Specialist Register for dentists qualified in various specialist fields of dentistry for the purpose of formalizing the granting of specialist title by the Dental Council. The proposed amendments will provide better clarity and certainty on the requirements and procedures for specialist registration. This will also help to facilitate development of specialist practice in the dentistry profession. We will consult the Panel on Health Services before introducing the amendment Bill into the Legislative Council this year.

Smoke-free Indoor Workplaces and other Public Places

8. The health hazards of smoking and passive smoking are irrefutable. Since 1997 when the Smoking (Public Health) Ordinance was last amended, there have been continuous community calls for expanding the statutory no smoking areas to protect the working population and members of the public from passive smoking. The adoption of the Framework Convention on Tobacco Control by the World Health Organization in 2003 has heightened the momentum for tightening tobacco control legislation worldwide. In October 2004, the Legislative Council passed a motion for expeditious implementation of a total smoking ban in workplaces, restaurants and other indoor public areas. Against such background, we would seek to introduce legislative amendments into the Legislative Council in the second quarter of 2005 to

ban smoking in indoor workplaces and public places in Hong Kong. We look forward to Members' continued support in this regard.

On-going initiatives

9. In addition to the above New Initiatives, as set out in the 2005 Policy Agenda, HWFB is also pursuing a number of on-going initiatives in respect of health. The tasks that will be carried out in 2005 are highlighted below.

Protection from Undesirable Health Claims

10. The Undesirable Medical Advertisements (Amendment) Bill was introduced to the Legislative Council in October 2004. The Bill aims to regulate health claims of orally consumed products relating to the regulation of certain body conditions, for which we consider the public should seek proper medical consultation. A Bills Committee has been set up to scrutinize the Bill. We are working closely with the Bills Committees and the relevant stakeholders with a view to completing the amendments as soon as possible.

Risk-based Regulatory Framework on Supply and Use of Medical Devices

11. In 2003, the Government proposed to develop a risk-based regulatory framework to control the supply and use of medical devices to protect public health and ensure continued access to new and safe devices. In this connection, the first phase of the Medical Device Administrative Control System (MDACS) was launched in November 2004, commencing with the listing of those devices of highest risk. This will be followed by the listing of manufacturers and importers and implementation of an adverse incident reporting system. A Working Group involving relevant stakeholders has been formed to work on both the scope of application and the level of training required for non-health personnel to operate certain high-risk devices like IPL equipment. This Administrative Control System will be expanded by phases to devices carrying relatively lower risks in 2005.

Regulating Chinese Medicine (CM) and introducing CM into the public health care system

12. Taking into account operation experience of three CM clinics

operating in HA hospitals, the Administration aims to increase the number of CM clinics to no fewer than six in 2005-06 by stages. In determining the location of these clinics, we will take into account concentration of senior citizens in a particular district. CSSA-receiving senior citizens and those in financial difficulty will enjoy full or partial fee exemption in these clinics. The clinics will also provide training opportunities for some local CM graduates. We aim to consult the Health Services Panel and seek capital works funding support from the Legislative Council's Finance Committee within the 2004-05 legislative session.

Enhancing Primary Medical care to reduce reliance on hospital care and developing a Pluralistic Primary Care Model

13. Family medicine (FM) practice is a core element of enhancing primary care. FM is a specialized discipline of medicine that provides primary, continuing and comprehensive care to an individual and the family in their own environment. Since 1997/8, a total of 534 doctors have been enrolled in a four-year, structured, supervised training programme in family medicine.

14. Furthermore, the HA has taken over the General Outpatient Clinics (GOPCs) from the DH in July 2003 and this provided a basis for the development of an integrated community-based health care model. HA is extending its clinical management computer system to the GOPCs in phases. The transfer has made possible vertical integration between specialist and general outpatient clinic services. Where appropriate, hospital clusters now gradually download stable chronic patients from the specialist outpatient clinics to GOPCs, freeing up the more expensive specialist outpatient services for those in need. After the transfer, HA has also involved community-based medical, geriatric, psychiatric, gynaecology and paediatric specialists to provide consultation service in some of the GOPCs in an effort to reduce case referrals and improve the quality of care for chronically ill patients in GOPCs.

15. To improve primary care for the elderly in the community, HA's Community Geriatric Assessment Teams (CGAT) have been strengthened with support from Visiting Medical Officers (VMOs). Under the VMO scheme, private practitioners have been recruited to provide regular visits to residential homes for the elderly for on-site management of episodic illness of residents with the objective of reducing hospital admissions and enhancing the quality of care.

Health Care Services Development and Health Care Financing

16. Throughout the years, our health care system has evolved in response to social development and changes. However, the process has sometimes inadvertently resulted in skew developments. The much quoted 'imbalance' between the public and private sector is an example. With an aging population and increasing demand for provision of highly subsidized services, it would be prudent for our public health care services, i.e., services provided by the Hospital Authority, to move towards the four targeted and priority areas of –

(a) acute and emergency care;
(b) services for the low income group and the underprivileged;
(c) illness that entail high cost, advanced technology and multi-disciplinary professional team work in their treatment; and
(d) training of health care and other professional staff.

17. We should also move towards an integrated community-based health care service model and to this end, enhancement of intersectoral collaboration would be warranted. We expect to see the Hospital Authority, Department of Health, Social Welfare Department and Education and Manpower Bureau align their services so that there is an improvement in the interfacing between healthcare, welfare and education services and ownership at the district level. This would ensure that responsive and coordinated services are provided for the community. The pilot Head-Start Programme for children in the 0-5 age bracket to be undertaken in the 4 pilot communities, using Maternal and Child Health Centres as a platform for interfacing, is an example of integrated and comprehensive service provision.

18. Re-affirmation of the service positioning including improving the interface between the public and private health care sectors and delivery mode would facilitate us in examining our health care financing options. We also need to further explore ways to enhance our health care system. In this connection, we would work closely with the Health and Medical Development Advisory Committee. This Committee which is being reconstituted will comprise public and private health care professionals, academics, community leaders and other experts. As stated in the 2005

Policy Agenda, we will undertake studies within the next two and a half years to help lay the foundation for the formulation of long term strategies.

Sustainable long-term funding arrangement for the Hospital Authority

19. The funding arrangement for HA was changed from being input– or facility-based to basing on population needs and specific programmes since 2001/02. In recent years, HA's budget has seen successive deficits. While we have continued to provide funding for specific programmes such as strengthening infection control measures, we have begun to consider how best should the funding arrangement for HA be further changed to enable the organization's operation to be sustainable. We will take into consideration the factors that have been affecting HA's workload, such as the growth rate of the elderly population, disease trends, emergence of expensive new medical technology and drugs and the international trend in providing public sector health services. The exercise will be conducted against the background of re-positioning public sector health services (see paragraph 16 above), integration of service provision by HA and other departments (see paragraph 17) and examination of healthcare financing options (see paragraph 18).

Health, Welfare and Food Bureau
January 2005

ANNEX

2004 Policy Agenda –Progress and Achievements

Enhance our preparedness against the outbreak of infectious diseases

An overall contingency mechanism, underpinned by detailed contingency plans of relevant departments, has been established to set out a clear command structure for making and implementing decisions. Central to this contingency mechanism is a three-level response system to ensure the Government's swift decision making in handling major infectious disease outbreaks. Premised on this system, a contingency plan for flu pandemic is also being finalized. In November 2004, the CHP organized and conducted a large-scale inter-departmental exercise on an outbreak of infectious disease, namely the Exercise MAPLE, to review procedures as set out in the contingency plans.

2. A great deal of efforts have been made by the Guangdong Province, Macao and Hong Kong to ensure prompt and timely exchange of important information about infectious disease outbreaks and incidents. The epidemic intelligence exchange and experience sharing with health authorities in the Mainland and Guangdong has been institutionalized.

3. Information about statutory notifiable diseases of the three places as well as infectious diseases of concern is exchanged on a monthly basis. The three places also agreed to start collaboration on scientific research and strengthen exchange and collaboration on surveillance, exchange planning and development of admission and treatment facilities for infectious diseases, and enhance training and visit of professionals in public health and infectious diseases.

4. Effective communication and coordination are vital at every level when dealing with a major disease outbreak. A population-based, and cross-sectoral approach is adopted for effective prevention and control of infectious diseases. Since the SARS outbreak, departments/agencies including Department of Health and Hospital Authority, as well as various sectors of the community, including private doctors and hospitals, NGOs and voluntary sectors, have been making tremendous efforts in enhancing their preparedness and capability against

infectious diseases.

Enhance Hong Kong's capacity to prevent and control communicable disease outbreak by setting up a Centre for Health Protection

5. The Centre for Health Protection (CHP) was set up on 1 June 2004 as a new public health infrastructure under the Department of Health with responsibility, authority and accountability for the prevention and control of infectious diseases. Its mission is to achieve effective prevention and control of diseases in Hong Kong in collaboration with local and international stakeholders. The CHP has six functional branches which work cohesively to help leverage available resources to respond to public health threats and emerging issues as well as chronic health conditions. A Board of Scientific Advisers and various Scientific Committees, comprising scientists and academics from different fields, are set up under the CHP to advise CHP on issues relating to diseases of public health importance.

Building up surge capacity by providing additional isolation facilities in designated acute hospitals

6. Newly constructed, modern isolation facilities with capacity to handle 1400 patients have now been established in 14 acute public hospitals. In addition, an infectious disease centre will be established in Princess Margaret Hospital.

Conduct research relating to infectious diseases such as diagnostic techniques for SARS and clinical management of SARS and providing more public health training to healthcare workers

7. Research Fund for the Control of Infectious Diseases has been set up to encourage, facilitate and support research on the prevention, treatment and control of infectious disease, in particular emerging infectious diseases such as SARS. As at end 2004, the Fund has provided support to research projects headed by the University of Hong Kong, the Chinese University of Hong Kong and a consortium headed by the Hospital Authority, as well as 35 investigator-initiated research projects on infectious diseases covering aetiology, epidemiology and public health, basic research, clinical and health services.

8. In addition, DH has been liaising with local academic institutions and overseas field epidemiology training programmes to enhance its

training capacity. Attachment opportunities to the Centre for Disease Control and Prevention Atlanta and Health Protection Agency of the United Kingdom are being explored to enhance workforce competence and capacity. Between October 2003 and November 2004, DH provided training to a total of 4,331 medical/nursing/paramedical staff on infection control and infectious disease epidemiology. In addition, the Infectious Disease Control Training Centre sponsored 18,000 healthcare workers to basic infection control training and 3,200 staff to specialist training. Another 500 staff received local and overseas sponsorship on specific programs.