For information on
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Legislative Council Panel on Health Services
Healthcare Service Reform - Shared Care Programme

PURPOSE

This paper briefs Members on the details of the Shared Care Programme to be introduced by the Government through the Hospital Authority (HA), and the latest progress of other pilot projects to enhance support for chronic disease patients in the primary care settings.

BACKGROUND

2. Enhancing primary care services is one of the proposals put forward in the first stage public consultation on healthcare reform conducted from March to June 2008, and has received broad public support. In his 2008 Policy Address, the Chief Executive announced the implementation of a series of pilot projects to enhance support for chronic disease patients in the primary care settings as part of the healthcare service reform. Starting from 2009-10, the Government launched, through HA, a series of pilot projects to enhance primary care services to strengthen the management of chronic diseases and enhance support for chronic disease patients through multi-disciplinary and cross-sector collaboration with a view to reducing complications and the need for hospitalisation. Under the pilot projects, the public and private healthcare sectors and/or non-governmental organisations (NGOs) join hands to provide comprehensive and multi-disciplinary healthcare services to chronic disease patients.

OBJECTIVES OF THE PROGRAMME

3. The Shared Care Programme is one of the pilot projects and will last for three years. It aims to allow chronic disease patients currently under the care of the public healthcare system to choose to receive comprehensive care from private doctors. At present, more than 500 000 chronic disease patients are receiving follow-up treatment at specialist out-patient clinics (SOPCs) under HA. Many of them are in stable conditions and can receive treatment in the primary care settings.

4. Currently, chronic disease patients who receive treatment at public SOPCs and are clinically stable can be referred to neighbouring public general out-patients clinics (GOPCs) to follow up on their conditions. The Shared Care Programme provides additional choices of private services for these patients and allows patients to choose neighbouring private doctors of their choice to follow up on their conditions, receive partial subsidy for receiving comprehensive management, and establish long-term patient-doctor relationships in order to achieve the objective of continuous and holistic care. The public healthcare system will continue to provide support.

5. Through this pilot project, the Government seeks to assess the efficacy of the primary care conceptual model and clinical protocols for diabetes mellitus (DM) and hypertension (HT) developed by the Working Group on Primary Care[1] in controlling medical conditions; test a service model for provision of public-private shared care for chronic disease patients; promote the involvement of private primary care doctors in the prevention and treatment of chronic diseases; and enhance the capability of the healthcare system in providing more comprehensive and continuous care for chronic disease patients. All these will in turn foster public-private partnership and make better use of resources in both public and private healthcare sectors, which will enhance the efficiency of the healthcare system in improving the health of the population.

6. The pilot Programme can also provide choices of more flexible private services outside the public system to chronic disease patients who are under the care of the public healthcare system. The Programme will ensure that the private services will follow the appropriate chronic disease care model and clinical protocols. The Government will provide partial subsidy. The public healthcare system will also continue to monitor the conditions of patients, provide adequate support for private doctors and patients, and allow patients with deteriorating conditions to go back to SOPCs for timely management. The Government will also closely monitor the

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[1] The Working Group on Primary Care under the Health and Medical Development Advisory Committee was reconvened in October 2008 as announced by the Chief Executive in the 2008 Policy Address. It is chaired by the Secretary for Food and Health and its members include representatives from medical professionals, academia, patient groups and other stakeholders. It provides strategic recommendations on enhancing and developing primary care in Hong Kong. The Working Group has set up three Task Forces, which are responsible for studying primary care conceptual model and clinical protocols, Primary Care Directory and primary care service delivery models respectively. The Working Group and the Task Forces made initial recommendations on enhancing and developing primary care in 2009, including developing and promoting clinical protocols for managing individual chronic diseases, developing and promoting a Primary Care Directory, and formulating proposals to launch pilot projects in various districts to set up community health centres and networks under different service models to provide more comprehensive primary care services.

implementation and effectiveness of the Programme to ensure that chronic disease patients who voluntarily participate in the Programme are receiving the appropriate care.

PROGRAMME DETAILS

Target Groups

7. In the initial stage, the pilot Programme will primarily target at DM and HT patients who are currently taken care of by the public healthcare system. They must have started to receive care for DM and HT at public SOPCs at least two years ago. They must also be assessed to be clinically stable and can continue to receive care in the primary care settings. These include those DM and HT patients who previously received care at public SOPCs but have been referred to GOPCs for continuous follow-up.

Pilot Districts

8. We will first pilot the Programme in Tai Po and Shatin. All private doctors practising in these two areas can choose to participate in the Programme. HA will assess the conditions of DM and HT patients who are currently under the care of public SOPCs and GOPCs in Tai Po and Shatin, and send invitation letters to eligible patients. Patients who voluntarily choose to participate in the Programme can select a doctor from the list of private doctors for continuous follow-up on their conditions, and receive a package of comprehensive care services jointly provided by the public and private healthcare sectors[2]. Patients who do not choose to participate in the pilot Programme will continue to be taken care of by HA's public SOPCs or GOPCs.

Subsidy for Patients

9. During the pilot period, the Government will create an electronic healthcare voucher account for each participating patient and deposit into the account a maximum subsidy of $1,400 per year in the form of electronic health care vouchers. The subsidy covers the following two items:

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[2] To ensure the provision of continuous care for participating patients, each patient has to receive care from the same private doctor for at least one year. After one year, patients with good cause may request to switch private doctors. Arrangements will be made by the HA on a case-by-case basis.

(i) A subsidy of $1,200 for consultation/case management and drugs

10. Each participating patient will receive $1,200 per year from the Government for subsidising consultation/case management provided by private doctors and drugs for treating DM and HT.

11. Participating doctors are required to provide patients with comprehensive and continuous care based on the conceptual model and clinical protocols developed by the Working Group on Primary Care. Private doctors have to provide patients with a minimum of four consultations per year (normally four to six consultations are required) at an interval of not more than four months between each consultation to ensure the continuity of care provided to patients[3]. Patients will collect drugs at private doctors' clinics.

12. On top of the $1,200 subsidy provided by the Government, participating patients have to pay out-of-pocket the fee listed by private doctors for providing services for treating DM and HT according to specified care model and clinical protocols, as well as the fee for any other additional (not subsidised) services (see paragraphs 16 and 17 below). Elders who are aged 70 or above and have participated in the Elderly Health Care Voucher Pilot Scheme[4] can use the subsidy provided under the Shared Care Programme together with their elderly health care vouchers when they receive consultations.

(ii) An incentive of $200

13. To encourage patients to participate more actively and continuously in the management of chronic diseases, the Government will provide an incentive of up to $200 per year for patients who can meet the preset health outcome indicators and complies with the care requirements prescribed by their doctors (such as regular follow-ups and drug compliance). Subject to confirmation of achieving the indicators every 12 months after the patients' participation in the Programme, the incentive will be deposited in the electronic healthcare voucher accounts of eligible patients for their use in future consultations[5].

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[3] The actual number of consultations is subject to discussion between doctors and patients in light of clinical needs and patients' wish.

[4] The Elderly Health Care Voucher Pilot Scheme was launched in 1 January 2009 for three years to provide five electronic health care vouchers of $50 each annually to elders aged 70 or above to subsidise their use of private primary care services.

[5] The incentive can be used for the treatment related to DM and HT, other chronic diseases and episodic illnesses.

Incentive for Doctors

14. Besides, to encourage the doctors to provide treatment to patients to meet specified process indicators (e.g. measuring blood pressure and body weight and conducting annual health risk assessment), the Government will provide quality incentive of $200 each year to participating doctors for each patient under his/her care in the Programme. Doctors must meet all process indicators in order to receive the payment. Subject to confirmation of achieving the indicators, the incentive payment will be paid to the patient's doctor every 12 months after the patient has joined the Programme.

15. HA will provide a set of clinical protocols developed by the Working Group on Primary Care as well as a checklist of process indicators and health outcome indicators for reference by participating doctors.

Charging Arrangements of Doctors

16. Participating private doctors are required to publicise upfront the fees that they expect to charge each patient per year for treating DM and HT on top of the subsidy amount. Private doctors must notify HA in advance when if they intend to adjust their fees. They are also required to document in an electronic system the fees charged for any service used for treating DM and HT (see paragraph 20 below).

17. Participating patients may choose to receive services provided by their private doctors which are not covered under the Shared Care Programme or are not related to the management of DM and HT. However, such services will not be subsidised and patients have to pay out-of-pocket in full the fees charged by private doctors.

Other Support Services

18. Apart from consultation/case management and drugs provided by the private doctors that they have selected, participating patients can also receive laboratory services and health risk assessments provided by HA as specified in the clinical protocols and through private doctors' referral. Private doctors can, on the basis of clinical diagnosis, refer patients to HA for additional laboratory services related to treatment of DM and HT. HA will not charge patients additional fees for such services.

19. To provide patients with comprehensive multi-disciplinary healthcare services, doctors can refer patients to join the multi-disciplinary Risk Assessment and Management Programme and the Patient Empowerment Programme implemented by HA mentioned in paragraphs 26 and 27 below. If specialist assessment is required due to occurrence of disease complications or other problems, private doctors may refer the patients back to the public SOPCs for timely follow-up as appropriate.

Electronic System

20. Participating private doctors are required to enter patients' clinical information through an electronic system and share the patients' health records with HA's Clinical Management System. Besides, doctors are required to enter the services which are related to the management of DM and HT and their fees, including prescription of drugs on and outside the HA Drug Formulary, and laboratory services. Doctors are also required to provide information used to assess process and health outcome indicators through the system.

Support Provided for Doctors

21. HA will organise training and sharing sessions to enhance private doctors' capability in providing comprehensive and continuous care for chronic disease patients so as to facilitate communication and experience sharing between the public and private healthcare sectors.

PROGRAMME EVALUATION

22. HA will engage an independent assessment body to continuously evaluate the arrangements and effectiveness of the Programme during the pilot period. The Government will consider whether the Programme needs to be improved and should be extended to other districts having regard to the evaluation results and experience from the Programme.

PROGRAMME IMPLEMENTATION

23. The Food and Health Bureau and the New Territories East Cluster of HA have consulted private doctors practising in Tai Po and Shatin as well as relevant doctor groups on the Programme. The current arrangements of the Programme have taken into account their views. HA plans to invite private doctors practising in Tai Po and Shatin to participate in the Programme starting from March 2010. At the

same time, HA is about to compile a list of eligible patients under the programme and plans to send invitation letters to eligible patients in batches and arrange briefing sessions to introduce the Programme details starting from April 2010.

24. HA will set up help desks at the Alice Ho Miu Ling Nethersole Hospital in Tai Po and the Prince of Wales Hospital in Shatin as well as a telephone hotline to answer enquiries from members of the public, patients and private doctors on operation details of the Programme and to provide support to those who have participated in the Programme.

OTHER PILOT PROJECTS TO ENHANCE SUPPORT FOR CHRONIC DISEASE PATIENTS

25. Apart from the Shared Care Programme mentioned above, the Government has also launched in phases, through HA, several pilot projects to enhance support for chronic disease patients in the primary care settings as detailed below. These include promoting the prevention and treatment of chronic diseases in both the public and private sectors in local communities, conducting health risk assessments and drawing up management plans for high-risk groups, helping chronic disease patients improve their self-care skills through enhanced education, etc.

(i) Multi-disciplinary Risk Assessment and Management Programme

26. Since August 2009, HA has implemented the pilot project in designated GOPCs in the Hong Kong East and New Territories East Clusters. Multi-disciplinary teams of professional healthcare personnel including nurses, dieticians, pharmacists, etc. are set up to provide comprehensive health risk assessments for DM and HT patients of public GOPCs so as to provide appropriate control of disease conditions and follow-up to patients. HA will extend the programme to all the seven clusters across the territory in phases from 2009-10 to 2011-12.

(ii) Patient Empowerment Programme

27. Starting from March 2010, HA will launch a pilot Patient Empowerment Programme in collaboration with NGOs in the Hong Kong East and New Territories East Clusters to teach chronic patients to improve their lifestyle, so as to raise their awareness of the diseases and enhance their self-care ability. Under the programme, a multi-disciplinary team comprising allied health professionals from HA will develop appropriate teaching materials and aids for various types of common chronic

diseases and provide training for the frontline staff of the participating organisations. The programme will target at DM and HT patients in the initial stage and will be extended to cover other chronic disease patients later.

(iii) Nurse and Allied Health Clinics

28. Nurse and Allied Health Clinics comprising nurses and allied health professionals have been established by HA in selected GOPCs in its seven clusters starting from August 2009 to follow up on the cases of high-risk chronic disease patients, including those who require specific care services or are suffering from certain complications. HA will provide specific care support services in a number of areas such as fall prevention, handling of respiratory problems, wound care, mental health, etc. for individual chronic disease patients according to their conditions.

(iv) Purchasing haemodialysis services from the private sector or NGOs for end stage renal disease patients currently under the care of public hospitals

29. Currently, end stage renal disease (ESRD) patients followed up by HA are usually treated by peritoneal dialysis (PD). However, a small number of them need to receive haemodialysis (HD) services because of the undesirable effect of PD. In March 2010, HA will start implementing a three-year pilot project under which ESRD patients being followed up by HA will be given a subsidy to receive HD services provided by the private sector or NGOs[6]. HA will continue to provide specialist out-patient services, drugs and laboratory services to participating patients. They can also keep their place on HA's organ transplant waiting list.

(v) Subsidising certain patient groups under the care of the GOPCs for primary healthcare services in Tin Shui Wai (TSW)

30. HA launched a three-year pilot project in TSW North in June 2008, allowing chronic disease patients in stable conditions and in need of long-term follow-up treatment at public GOPCs to voluntarily participate in the pilot project and receive treatment from participating private doctors practising in the district. HA will pay fees to participating doctors in accordance with the service contract while

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[6] The HD centres operated by the private sector or NGOs are located in six clusters of HA, including Hong Kong East, Hong Kong West, Kowloon Central, Kowloon East, Kowloon West and New Territories East hospital clusters. However, ESRD patients being followed up by HA in any of the seven hospital clusters across the territory can choose to participate in the pilot project.

participating patients are only required to pay the same fee as charged by GOPCs. The programme aims to strengthen the public general out-patient services in the district in order to address the increasing service demand and enhance the medical care rendered to chronic disease patients. As at end January 2010, six practising private doctors in TSW North and over 1 128 patients have participated in the pilot project. In view of the positive feedback on the pilot project, the service area will be extended to cover TSW South as planned.

ADVICE SOUGHT

31. Members are invited to note the content of this paper.

Food and Health Bureau
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