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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 12 February 2018

Development of primary healthcare services

Purpose

This paper provides background information on and summarizes the concerns of the members of the Panel on Health Services ("the Panel") on the development of primary healthcare services.

Background

2. According to the World Health Organization ("WHO"), "primary health care" is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.[1] The sixty-first session of the WHO Regional Committee for the Western Pacific[2] endorsed in October 2010 the Regional Strategy on Health Systems Strengthening Based on the Values of Primary Health Care. According to the Regional Strategy, primary health care is closely related to but not synonymous with primary care. The former encompasses a public health approach as well as individual care at primary, secondary and tertiary levels. A strong primary care system is the foundation for a health system based on primary health care values. However, secondary and tertiary services that connect to the primary care system are also vital and must connect to the primary care system.

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1 The Declaration of Alma-Ata adopted by WHO in 1978.

2 Hong Kong is an area in the WHO Western Pacific Region.

3. In Hong Kong, the Working Party on Primary Health Care issued the report entitled "Health for All – The Way Ahead" in 1990. In 2005, the Health and Medical Development Advisory Committee[3] ("the Advisory Committee") reviewed the service delivery model for the healthcare system and issued the discussion paper "Building a Healthy Tomorrow". The Advisory Committee made, among others, a number of recommendations on primary care which included (a) promoting the family doctor concept which emphasized continuity of care, holistic care and preventive care; (b) putting greater emphasis on prevention of diseases and illnesses through public education and family doctors; and (c) encouraging and facilitating medical professionals to collaborate with other professionals to provide co-ordinated services. Building on the recommendations of the Advisory Committee, the Government put forth, among others, a package of healthcare service reforms in the First Stage Healthcare Reform Consultation Document entitled "Your Health Your Life" in March 2008. A reform proposal introduced therein was to enhance primary care.[4] It was proposed that the Government would take forward the recommendations by (a) developing basic models for primary care services; (b) establishing a family doctor register; (c) subsidizing patients for preventive care; (d) improving public primary care; and (e) strengthening public health functions. The reform proposal received broad support during the public consultation exercise.

4. To take forward the policy initiatives to enhance primary care as announced in the 2008-2009 Policy Address, the Working Group on Primary Care, chaired by the Secretary for Food and Health, was reconvened in 2008 to advise on strategic directions for the development of primary care in Hong Kong. Based on the advice of the Working Group, the Food and Health Bureau ("FHB") published the Primary Care Development Strategy Document in December 2010 in which primary care is described as the first point of contact of the whole healthcare system, which covers a wide range of services, including health promotion, prevention of acute and chronic diseases, health risk assessment and disease identification, treatment and care for acute and chronic diseases, self-management support, and supportive and palliative care for end-stage

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[3] The Health and Medical Development Advisory Committee is an advisory body, chaired by the Secretary for Food and Health, tasked to review and develop service models for healthcare in both the public and private sectors, and to propose long-term healthcare financing options.

[4] According to the First Stage Healthcare Reform Consultation Document, primary medical care (or primary care in short) refers to the medical part of primary health care which is the first contact of patients with their consulting doctors. In this context, primary curative care is currently predominately provided by the private sector by solo practitioners or group practices, and is also provided by the Hospital Authority through its general outpatient clinics mainly to the low-income, chronically-ill and poor elders.

diseases or disabilities. The identified major strategies to improve primary care in Hong Kong included: (a) develop comprehensive care by multi-disciplinary teams; (b) improve continuity of care for individuals; (c) improve co-ordination of care among healthcare professionals across different sectors; (d) strengthen preventive approach to tackle major disease burden; (e) enhance inter-sectoral collaboration to improve the availability of quality care, especially care for chronic disease patients; (f) emphasise person-centred care and patient empowerment; (g) support professional development and quality improvement; and (h) strengthen organisational and infrastructural support for the changes.

5. To support the development of primary care in Hong Kong and co-ordinate the implementation of various projects to enhance primary care, the Primary Care Office[5] was established in September 2010 under the Department of Health ("DH"). To date, the major primary care initiatives being taken forward by the Primary Care Office are as follows:

(a) the development of primary care conceptual models and reference frameworks with emphasis on the prevention and management of common chronic diseases: reference Framework for diabetes care, hypertension care and preventive care in children as well as older adults have been developed;

(b) the setting up of a Primary Care Directory to promote family doctor concept: the website and mobile website of the sub-directories of doctors, dentists and Chinese medicine practitioners have been launched; and

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[5] The major functions of Primary Care Office are:
(a) to co-ordinate public and private healthcare providers and other stakeholders in the implementation of population-wide policies and strategies to enhance primary care;
(b) to plan and oversee public education regarding continuing promotion of good primary care;
(c) to draw on appropriate professional advice on the development and promotion of primary care conceptual models, clinical reference frameworks for major diseases, and preventive reference frameworks for different age groups;
(d) to establish and maintain the Primary Care Directory;
(e) to explore, plan and implement different primary care service delivery models;
(f) to support the development of primary care providers and primary care-oriented training for healthcare professionals;
(g) to conduct and co-ordinate research projects in order to assess the needs for primary care services in Hong Kong and to work with independent assessment bodies to evaluate the effectiveness of reform initiatives; and
(h) to provide secretariat support to the Advisory Committee on Primary Care Directory and the Advisory Groups on Reference Frameworks.

(c) the establishment of Community Health Centres ("CHCs"): the Tin Shui Wai (Tin Yip Road) CHC, the first of its kind which was designed based on the primary care development strategy and service model, was commissioned in February 2012 to provide integrated and comprehensive primary care services for chronic diseases management and patient empowerment programme. The North Lantau CHC and Kwun Tong CHC commenced services in September 2013 and March 2015 respectively. Allied health services have been strengthened in CHCs.

6. Other projects and initiatives to enhance primary care implemented by other divisions of DH include health promotion and education, prevention of non-communicable diseases, the Vaccination Subsidy Scheme, the Elderly Health Care Voucher Scheme ("the EHV Scheme"), the Colorectal Cancer Screening Pilot Programme ("the CRC Pilot Programme") and the Outreach Dental Care Programme for the Elderly. Separately, the Hospital Authority ("HA") has implemented various initiatives to enhance chronic diseases management since 2008-2009, which include the Risk Factor Assessment and Management Programme, the Patient Empowerment Programme, Nurse and Allied Health Clinics, the Tin Shui Wai Primary Care Partnership Project, and the General Outpatient Clinic Public-Private Partnership Programme ("the GOPC PPP Programme").

Deliberations of the Panel

7. The Panel discussed issues relating to the development of primary care at various meetings. The deliberations and concerns of members are summarized in the following paragraphs.

Primary care conceptual models and clinical protocols

8. While expressing support for enhancing primary care, members were concerned about how the development of clinical protocols would benefit patients in the primary care setting. There was a view that the primary care conceptual model and clinical protocols might only serve as a reference for private doctors participated in the public-private partnership initiatives launched by HA in understanding the treatment provided by HA.

9. The Administration advised that the primary care conceptual models and clinical protocols for chronic diseases and age-specific/sex-specific health problems would not only provide the public as well as the healthcare professionals in both the public and private sectors with a framework on what a

comprehensive range of primary care services should cover, but also provide common reference to guide and co-ordinate the efforts of healthcare professionals across different sectors for the provision of continuing, comprehensive and evidence-based care for managing common chronic diseases in the primary care setting. The conceptual models and clinical protocols would empower patients and their carers, and raise the public's awareness on the importance of preventing and properly managing the major chronic diseases. It should be noted that clinical protocols were widely used internationally in different health systems, including that of the United States.

Primary Care Directory

10. Question was raised on the need for setting up the Primary Care Directory as the public would usually choose the network doctors of their medical insurance schemes or neighbouring private doctors in the vicinity of their residence or working place. The Administration advised that the development of a Primary Care Directory containing practice-based information of primary care professionals of various disciplines in the community was supported by patients and primary care practitioners. The Directory would provide patients with adequate information to help them choose their primary care providers in the community, as well as facilitate the co-ordination among different primary care providers functioning as multi-disciplinary teams.

11. Some members cast doubt on the effectiveness of the Primary Care Directory to serve as a starting point for promoting the concept of family doctor and preventive care. There was also a concern as to whether the Directory could attract the enrolment of family doctors as participation was on a voluntary basis. These members called on the Administration to engage family doctors to enhance communication with their patients, so as to foster a closer partnership between family doctors and patients and in turn change the existing habit of doctor-shopping. The Administration advised that the promotion of family doctor concept aimed at changing the healthcare seeking behavior. The Primary Care Directory could facilitate members of the public to choose primary care providers who could serve them as family doctors.

12. Question was raised about the timetable for inclusion of the information of various healthcare professionals in the Primary Care Directory. The Administration advised that a phased approach would be adopted in this regard. With the launch of the sub-directories of doctors, dentists and Chinese medicine practitioners, the next step was to develop sub-directories of other allied health professionals.

Establishment of CHCs

13. Members were concerned about whether case management approach would be adopted in the first purpose-built CHC, which was identified as a feasible service model to deliver community-based primary care services. Question was raised as to whether this mode of service would be extended to other districts.

14. According to the Administration and HA, the CHC in Tin Shui Wai would aim at providing one-stop, better co-ordinated, more comprehensive and multi-disciplinary primary care services to the public, with emphasis placed on the management of chronic diseases. Multi-disciplinary teams of professional healthcare professional would be set up to provide comprehensive health risk assessments for diabetes mellitus and hypertension patients. In addition, a Nurse and Allied Health Clinic would be established to provide high-risk chronic patients with more focused care in various areas. Members were advised that this new health facility with different healthcare services co-located in the same building was only one of the many different models of CHC. Other CHCs could be in form of creating virtual networks among different primary care providers of close proximity in the community.

Primary care services for the elderly

15. Members considered that the Administration should further enhance the primary care services for the elderly in the face of an ageing population. In particular, measures should be put in place to shorten the waiting time for and enhance the service capacity of the Elderly Health Centres ("EHCs"), which provided health assessment, physical check-up, health education, individual counselling and curative treatment to elders aged 65 or above. Consideration should also be given to establishing more EHCs to meet the service needs.

16. Members were advised that manpower would be increased to enhance the capacity of and the services provided by EHCs and allocate more first-time health assessment quotas to new members. Having critically reviewed the strategic direction of EHCs, DH would implement a pilot collaborative model at EHCs with NGOs to reach the "hard-to-reach" elderly, review the health assessment protocol to channel more resources into conducting first-time health assessments for new members and seek additional resources to enhance the service capacity of EHCs.

17. Members had all long held a strong view that the eligible age of the EHV Scheme, which was launched in 2009 to subsidize eligible elderly to use primary

care services provided by the private sector, should be lowered from 70 to 65, if not to 60, years old. The health care voucher amount should also be increased. In response, the Administration had increased the annual voucher amount to $2,000 when the EHV Scheme was converted from a pilot project into a recurrent programme in 2014. The eligibility age for the EHV Scheme was lowered from 70 to 65 years old in July 2017. Members were of further views that the financial cap on the cumulative amount of the vouchers in the account of the eligible elderly should be revised upward, say from $4,000 to $8,000. In addition, consideration should be given to allowing eligible elderly couples to share between themselves the amount of vouchers in their voucher accounts.

General outpatient services

18. Members noted that HA had launched the GOPC PPP Programme in mid-2014 in three districts, namely Kwun Tong, Wong Tai Sin and Tuen Mun, with an aim to help relieve the demand for HA's general outpatient services by tapping resources in the private sector. At present, participating clinically stable patients with hypertension (with or without hyperlipidemia) and/or diabetes mellitus would receive up to 10 subsidized consultations provided by the participating private doctors each year, drugs for treating their chronic conditions and episodic illnesses from the private doctors and relevant laboratory and x-ray services provided by HA upon referral.

19. Members were concerned about the participation rate of patients and private doctors in the Programme, the drug costs to be borne by the participating private doctors which might be their prime consideration in deciding the drugs to be prescribed for patients, the medication arrangements for those participating patients who later suffered from other chronic diseases, and the monitoring of the quality of services provided by the participating private doctors.

Dental care services

20. Members expressed a strong view that the existing scope of public dental care service, which was confined to emergency dental treatment, was far from adequate to meet the dental care needs of the elders and people with disabilities. They noted that the Community Care Fund ("CCF") had rolled out in 2012 the Elderly Dental Assistance Programme ("the EDA Programme") to subsidize the needy non-Comprehensive Social Society Assistance ("CSSA") recipients aged 60 or above, who were users of the home care service or home help service scheme subvented by the Social Welfare Department to receive dentures and other necessary dental services (including scaling and polishing, filings, tooth extractions and x-ray examinations). In addition, free outreach dental care services were provided to elderly in residential care homes or day care centres

through outreach dental teams set up by non-governmental organizations ("NGOs"). The EDA Programme was expanded to cover Old Age Living Allowance recipients aged 80 or above in September 2015 and the age requirement was further lowered to those recipients aged 75 or above and 70 or above in October 2016 and July 2017 respectively. Separately, the Pilot Project on Outreach Primary Dental Care Services for the Elderly in Residential Care Homes and Day Care Centres was turned into a recurrent programme in 2014.

21. Despite the above enhancement measures, members were of the view that the number of elders benefited from the various dental care support initiatives was limited. They urged the Administration to take care of those elders living in the community who were in need of dental care services, especially those elders living in districts with lower household income and singleton elders not on CSSA. The Administration advised that subject to the availability of sufficient manpower in the dental profession, it would explore further measures to address the dental care needs of other groups of elders.

22. Considering that the annual voucher amount of the EHV Scheme was inadequate for an eligible elderly to cover the dental and various healthcare expenses, members had repeatedly called on the Administration to provide separate dental care vouchers for eligible elderly to receive dental care services in the private sector.

Health Assessment

Elderly Health Assessment Pilot Programme

23. Members considered that prevention and early identification of diseases could reduce the need for more intensive medical care and improve the efficiency of the whole healthcare system. They called on the Administration to provide free basic body checkup to member of the public. Members noted that the Administration had launched an Elderly Health Assessment Pilot Programme in 2013 to provide subsidized health assessment service for up to 10 000 eligible elderly aged 70 or above, in collaboration with nine NGOs. The Pilot Programme was particularly targeted at those elders who lived alone, who did not have health assessment before, or who did not have regular follow-up by medical services.

24. Members were subsequently advised that a review of the Pilot Programme showed that the lack of long-term curative and clinical follow-ups under the Pilot Programme had made it less attractive to the elderly, with only about 80% of the quotas used up at the end of the pilot period. Participating NGOs also faced various operational difficulties, such as recruitment of target elderly,

employment of suitable healthcare professionals, and the high administrative, laboratory and manpower costs. Hence, this new service delivery model would not be further pursued. Some members did not subscribe to the view of the Administration, as the Pilot Programme had achieved its objective of detecting previously unidentified health risks or problems of the participating elderly, including those hard-to-reach elderly.

The CRC Pilot Programme

25. Members were briefed that to address the rapid increasing burden of colorectal cancer, a CRC Pilot Programme would be launched to provide subsidized colorectal cancer screening for higher risk groups. The initial target group were eligible residents aged 61 to 70 at the time of programme launch. Under the two-tier screening protocol, participants with a positive faecal immunochemical test ("FIT") result would be referred by the private primary care doctors to undergo colonoscopy for assessment by a privately practised colonoscopist. They would be provided with a subsidy from the government and, as the case might be, a co-payment by the participant for the services.

26. Members considered that there was no reason not to support the CRC Pilot Programme. However, they were of the view that the age threshold set at 61 years old at the time of programme launch should be lowered. Some members were concerned that the CRC Pilot Programme would widen the gap between those FIT-positive participants who were able to afford the co-payment for undergoing colonoscopy in the private sector and those less privileged participants who could only resort to the public sector with a long queuing time. Those eligible persons with limited economic means might not participate in the Programme as they could not afford the co-payment for private endoscopy services if being tested FIT-positive and the drug expenses if being diagnosed as a confirmed case. These members suggested that a fully subsidy subject to mean test should be provided to the less privileged FIT positive participants.

Cancer screening for females

27. Members urged the Administration to consider providing regular gynaecological check-ups for all women and introducing a cervical cancer vaccination programme for girls in the relevant age group. Pointing out that breast cancer was the most common cancer among women in Hong Kong, some members called on the Administration to conduct population-based cancer mammography screening for women aged over 40 years old.

28. Members were advised that CCF would launch a three-year pilot scheme in October 2016 to provide free cervical cancer vaccination for teenage girls from eligible low-income families having regard to the finite public resources. For breast cancer, there was insufficient evidence to recommend for or against population-based breast cancer screening for asymptomatic women at average risk in Hong Kong. Hence, the Administration had commissioned a study to develop a locally validated risk prediction tool to identify individuals who were more likely to benefit from screening.

The most recent initiative on primary healthcare

29. Referring to the proposal to set up a steering committee on primary healthcare development as announced in the Chief Executive's 2017 Policy Address, members considered that the steering committee should draw up as soon as practicable a development blueprint for primary healthcare. Emphasis should be put on preventive care to reduce disease burden and step-down care in primary care setting to reduce the need for re-admission. Adequate financial and manpower resources as well as infrastructure support should also be made available to support the measures formulated to enhance primary healthcare.

30. On the proposal to establish a district health centre with a brand new operation mode in Kwai Tsing District, question was raised about the difference between the operation mode of the proposed district health centre and CHCs. The Administration advised that the multi-disciplinary healthcare services provided by CHCs covered, among others, general outpatient services and primary care services for chronic diseases management. The primary care services to be provided by the proposed district health centre would be based on the needs and characteristics of the district, with a view to enhancing the public's awareness on disease prevention and their ability in self-management of health through medical-social collaboration and procurement of services from organizations and healthcare personnel serving the district.

Recent developments

31. On 29 November 2017, the Steering Committee on Primary Healthcare Development was established, for a term of three years, to develop a blueprint for the sustainable development of primary healthcare services for Hong Kong. According to the Administration, the Steering Committee will comprehensively review the existing planning of primary healthcare services and devise service models to provide primary healthcare services via district-based medical-social collaboration in the community. The Steering Committee will be underpinned

by the Working Group on District Health Centre Pilot Project in Kwai Tsing District in taking forward the pilot district health centre in Kwai Tsing. The Steering Committee and the Working Group are chaired by the Secretary for Food and Health and the Under Secretary for Food and Health respectively.

Relevant papers

32. A list of the relevant papers on the Legislative Council website is in the **Appendix**.

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Appendix

Relevant papers on the development of primary healthcare services

Committee	Date of meeting	Paper
Panel on Health Services	14.4.2008 (Item V)	Agenda Minutes CB(2)2695/07-08(01)
	12.4.2010 (Item VI)	Agenda Minutes CB(2)1629/09-10(01)
	12.7.2010 (Item II)	Agenda Minutes CB(2)757/10-11(01)
	10.1.2011 (Item V)	Agenda Minutes
	21.1.2013 (Item IV)	Agenda Minutes
	20.1.2014 (Item III)	Agenda Minutes
	17.2.2014 (Item IV)	Agenda Minutes CB(2)2015/13-14(01)
	15.12.2014 (Item VI)	Agenda Minutes
	19.1.2015 (Item III)	Agenda Minutes
	16.3.2015 (Item V)	Agenda Minutes CB(2)1287/14-15(01)
	16.11.2015 (Item VI)	Agenda Minutes

Committee	Date of meeting	Paper
Panel on Health Services	18.1.2016 (Item IV)	Agenda Minutes
	20.6.2016 (Item III)	Agenda Minutes
	26.1.2017 (Item I)	Agenda Minutes
	17.7.2017 (Item V)	Agenda Minutes CB(2)455/17-18(01)
	16.10.2017 (Item IV)	Agenda

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