Legislative Council Panel on Health Services
Meeting on 12 December 2005

Public Response to the Health and Medical Development Advisory Committee Discussion Paper "Building a Healthy Tomorrow"

PURPOSE

This paper is to inform Members of the response received in the public consultation on the Discussion Paper entitled "Building a Healthy Tomorrow" ("the Discussion Paper") issued by the Health and Medical Development Advisory Committee (HMDAC).

BACKGROUND

2. The HMDAC, chaired by the Secretary for Health, Welfare and Food (SHWF), was tasked to review and develop the service model for healthcare in both the public and private sectors; and to propose long-term healthcare financing options. On 19 July 2005, the HMDAC released a discussion paper for public consultation until 31 October 2005. It put forth a host of recommendations for the future service delivery model for our healthcare system, covering primary medical care, hospital services, tertiary and specialized services, elderly, long term and rehabilitation care, as well as other related issues including private-public sector collaboration and infrastructural support for public discussion. The HMDAC intended to involve the community from the first step.

The discussion paper was therefore centred more on the direction of change rather than implementation details. If there is support in the community for the direction of change, the Government and the Hospital Authority (HA) will develop implementation details and consult the community or affected groups as reforms progress.

PUBLIC RESPONSES RECEIVED

3. About 600 written submissions were received in the public consultation exercise, of which about 130 were submitted in the name of organizations and the rest were individual submissions.

4. Respondents covered a wide spectrum of the community – patient groups, doctors in private practice as well as those in public service, medical associations, other allied health groups and organizations, elderly concern groups, academic bodies, NGOs, the middle class, political parties, business bodies and private hospitals.

5. In addition, SHWF, members of the HMDAC and representatives from the Health, Welfare and Food Bureau attended a total of 39 briefing sessions, seminars, District Council meetings and public forums to listen to views from various sectors of the community. A list of the sessions attended is at **Annex A**.

6. To facilitate greater participation by the middle class in the discussion of this subject, we had posted the Discussion Paper on the

Public Affairs Forum of the Home Affairs Bureau's website. A total of 77 messages were received. A summary of the views received is at **Annex B**.

7. A number of written submissions and over 2,000 signature/standard letters were received objecting to the alleged closure of the Accident & Emergency Department (A&E) of Ruttonjee Hospital in Wanchai. As these views were focused on a specific service of a particular hospital, they are outside the remit of the HMDAC. We have handled these views separately in accordance with established procedure.

OVERALL FEEDBACK

8. The majority of respondents agreed that it was timely to review our health care services to ensure its sustainability. Some views, however, expressed that the present system worked well and should not be tinkered with. There were others who held the view that the Paper had not provided sufficient statistical data to justify the case for reform. On the contrary, there were also views suggesting that the urgency for reform should have been more strongly emphasized.

9. There was support in principle from many respondents for the direction of change, such as more emphasis on primary health/medical care and better integration of the public and private sectors. On the other hand, many views commented that the Discussion Paper was not comprehensive because it did not explain how the service delivery model

would be financed. In the absence of these details, respondents expressed that it was difficult for them to agree or disagree with the specific proposals at this stage. Some commented that the Discussion Paper was too visionary. Others found it conceptual and lacking in implementation measures, making it difficult for them to determine whether the proposals were worth supporting. Quite a number of views expressed disappointment that the role of Chinese Traditional Medicine doctors and other allied health professionals were not explored in the current Paper.

10. Notwithstanding the above, respondents expressed a diverse range of views on the proposed service delivery model. Broadly speaking, public responses focused on four areas: enhancing primary/preventive health care as a direction, the "family doctor" concept, the repositioning of public hospital services and healthcare financing options. Questions and concerns were raised in some areas. In other areas, such as tertiary and specialized services, integration between the private and public sectors and infrastructural support, we received less feedback. Although the HMDAC had expressed that it would explore financing options as a next step, many respondents gave their views on this aspect.

11. Given that some views expressed support in principle but would like more implementation details, that some others expressed support conditional upon certain requirements being met, and that quite a number of views were expressed at discussion forums and seminars by

individuals representing his/her own self or a defined group, it is not possible to quantify them by numbers. We have, instead, prepared a qualitative summary of views as follows for Members' information in the following paragraphs. The follow-up action that the Government will take is also set out hereunder.

I. PRIMARY MEDICAL CARE SERVICES

Views in general

12. There was widespread support for promoting and strengthening our primary health care services. Some, however, suggested that more emphasis should be put on "preventive" rather than "medical" care. The "family doctor" concept was widely supported by medical professionals. Response from members of the public was, nevertheless, mixed - some expressed support, whilst many expressed concerns over "affordability" and "quality regulation". Some said that they were unfamiliar with the "family doctor" concept or were unclear as to how to identify their own family doctors. Concerns and doubts were also expressed over the feasibility of the family doctor concept in Hong Kong given people's mindset and the lack of a private medical sector that could inspire confidence in the population. Some agreed that the Government should set standards and benchmarks for family doctors in private practice, others suggested the establishment of a registration system and mandatory continuous education for family doctors.

Follow-up Action

13. The overwhelming support for the family doctor concept from the medical profession is encouraging. However, it is clear from the response of members of the public that more needs to be done to explain and promote this concept. We can also see from some of the responses that some people are concerned about the transparency in private family doctors' fees and about the standard of private practitioners. The Government will work with the medical profession to promote the family doctor concept. The Department of Health (DH) will explore co-operation opportunities with the medical profession, especially those who are practicing as family doctors, in such publicity. As for the training of family doctors, the HA will regularly review the training programme for Residents undergoing training in Family Medicine to help the doctors provide high quality service when they enter the private market. The Hong Kong College of Family Physicians encouraged all doctors interested in practising primary healthcare to participate in diploma courses in Family Medicine and Continuing Medical Education programmes in primary care. The feasibility of contracting out of general out-patient service as a means of benchmarking the quality of primary medical care will also be considered. As for the fee transparency of private family doctors, the Government will keep in close contact with the private medical sector to monitor developments therein. The Government notes that as more service providers enter the market, all service providers will have to compete to provide better service and will respond better to the demand of patients.

14. The Government will put more emphasis on disease prevention and health promotion. The DH has launched a public health information system which captures social, environmental and population health data. The data captured will help identify the effect of social and environmental factors on health. DH will be able to be more proactive in communicating health risk with members of the public and in targeting public health actions. The Government will also consider how better to engage family doctors in private practice in disease prevention activities.

II. HOSPITAL SERVICES

Views in general

15. Many supported that the public hospitals should target its services at the four areas as set out in the Discussion Paper, namely, acute and emergency care, the low income and underprivileged groups, illnesses that entail high cost, advanced technology and multi-disciplinary professional team work and training of healthcare professionals. At the same time, some expressed that public hospitals should provide equitable access to all and the middle class, being taxpayers, in particular, should not be denied such service. Quite a number of views asked for clearer definitions for "low income" and "underprivileged". Some suggested that the Government should improve on its current fee waiver mechanism to help the elderly and others who were in need.

16. As regards the recommendation of discharging chronic patients who were medically stable from SOPD to primary care doctors or family doctors, there were different views. Some views in the medical sector noted that there was overuse of specialist resources in taking care of conditions which could be adequately handled by the primary healthcare system. Some suggested that clinical pathways for referrals or discharge protocols should be explicitly defined and that the complaints system should be improved to help clinical staff to deal with the situation. Patient groups in general had reservations. Views on the establishment of 24-hour clinics were also mixed. Some agreed that this would bring convenience to members of the public whilst the medical sector generally had reservation, saying that the viability of 24-hour clinics depended on many factors and that Government interference was undesirable.

Follow-up Action

17. The HMDAC recommended in the discussion paper to prioritise its services for four target groups. This, however, does not mean that those who fall outside these four target groups will be denied public hospital services totally. What the HMDAC recommended was that the public sector would have to undertake full responsibility to provide service for the four target groups with or without the private sector participating in providing the service, while in other areas the public sector should seek a more balanced share of the market with the private sector in order to maximize human resources and facilities, with a balanced market distribution or public/private partnership or integration.

There is no intention to shift the service to the private sector entirely. This recommendation should be seen against a public market share of 95% of all in-patient bed days. It should also be borne in mind that a more balanced share of the market between the public and private sectors would help bring about healthy competition in the standard of services offered to patients. Nevertheless, it is understandable that members of the public, especially the middle class, are concerned with suggestions that may affect them. We will continue to explain our position to them.

18. Regarding the recommendation of discharging chronic patients who were medically stable from SOPD to primary care doctors or family doctors, we believe the worries that primary care doctors would not be able to provide appropriate care and that it would not be possible to enter the public specialist out-patient system again could be resolved by the working out and adoption of referral protocols and shared-care programmes by the public and private sectors. The HA has already implemented shared-care programmes on a limited scale and will seek to develop more programmes of this type for chronic patients.

II. TERTIARY AND SPECIALIZED SERVICES

Views in general

19. Overall, not much feedback was received in this area. There was support for increasing the patient co-patient element of these services, provided that the co-payment would not pose unreasonable financial

burden to patients and their families. But there were also views that disagreed with the proposal. There was also support for more public-private collaboration in this field.

Follow-up Action

20. We will consider the public views expressed on the patient co-payment element of tertiary and specialized services in future fee adjustment exercises. We note in particular the HMDAC's recommendation that the Government should maintain the principle of providing these services at a relatively higher subsidy rate because of the high costs of such services, and should cap the percentage of the patient's income and assets for the co-payment to limit the medical treatment's drain on the patient's resources.

21. The Government and HA will maintain regular liaison with the private sector and seek collaboration whenever opportunities arise. We will also consider engaging private sector doctors with experience in tertiary and specialized services to practice in public hospitals on a part-time basis. HA will draw up a set of rules on clinical practice and code of conduct to guide the private doctors in order to ensure a high standard of practice and assure the quality of care.

IV. ELDERLY, LONG-TERM AND REHABILITATION CARE SERVICES

Views in general

22. Among respondents who expressed their views, there was general support for a change from hospital-based to community-based model for elderly, long-term and rehabilitation care services which encouraged home care with community outreach and professional support. Many expressed concern over the adequacy, or otherwise, of manpower and resources to implement these changes and urged the Government to train more healthcare professionals of different streams to provide the service. There were, however, comments that geriatric care should be explicitly considered in the context of hospital care and community geriatric care.

Follow-up Action

23. We will explore how best to expand community care for the elderly, those who require long-term care and rehabilitation care services. The Social Welfare Department has already revised the Code of Practice for Residential Homes for the Elderly to encourage more frequent visit by doctors engaged by these Homes. We will work out proposals on the responsibilities of doctors engaged by these Homes and the related costs and then discuss with NGOs and the trade how best to implement this recommendation. For potential beneficiaries of Community Nursing care, the HA will consider an appropriate increase in the manpower of

Community Nursing Service (CNS) in the coming few years, taking into consideration the overall nursing manpower situation given the present manpower shortage problem. Consideration will be given to increasing CNS manpower on a wider scale when the nursing manpower situation has been relieved.

V. INFRASTRUCTURAL SUPPORT

Views in General

24. There was not much feedback on this area. Among those who responded, there was general support for more emphasis on preventive care, training of professionals in different roles and more rigorous public education on the importance of primary healthcare and healthy lifestyles. Some suggested that extra effort should be put on educating children and the elderly on primary healthcare. There was majority support for promoting free flow of patients' records, with some expressing concern on the sufficiency of protection for data privacy. The recommendation that the Government should put in place a fees and charges policy that is conducive to achieving the re-positioning of public healthcare services drew more diverse views. Supporters expressed that this would help discourage dependence on the public system while those expressed worries that some patients might not be able to afford increases in fees.

Follow-up Action

25. Apart from the ongoing efforts that DH has put and will continue to put in disease prevention and health promotion, the HA, as the largest health care provider in Hong Kong with a well-developed computerized patient dataset, has undertaken systematic analysis of health records to establish clearly the disease burden of the community. Based on this evidence, HA has formulated and put in place targeted disease prevention programmes. Examples are the district-based fall prevention and hypertension management programmes. In addition, evidence-based health promotion campaigns including "Better health for a better Hong Kong" have been launched to provide practical tips for the general public to maintain healthier life styles. The HA will continue to make use of patient health records to develop disease prevention programmes.

26. As for the recommendation of developing a territory-wide information system for carers in both public and private sectors to enter, store and retrieve patients' medical record, the Health, Welfare and Food Bureau will form a steering committee in early 2006 to oversee the development of the proposal. For the shorter-term future, General Out-patient Clinics in several clusters are using the HA's Clinical Management System to create a handheld paper record which patients can take with them when they visit other health care providers. This handheld record will be fully implemented in all GOPCs by 2006/07.

VI. OTHER VIEWS/SUGESTIONS

(A) Healthcare financing

27. The issue of healthcare financing was raised by many respondents. Many urged the Government to put forth financing options as soon as possible to facilitate discussion. Quite a number of respondents supported the "user-pay" principle provided that a safety net was in place ensuring everyone the right to have necessary medical care. Many suggested that the HA should review its structure and costs with a view to achieving better cost-effectiveness. Some suggested that the tax base be broadened. Some recommended introducing medical tax or devoting health-related tax revenue (e.g. taxes on tobacco or wines and spirits) to healthcare expenditure. There were views for and against mandatory contribution by the working population to a medical fund. There were also suggestions for a personal savings scheme.

28. The issue of medical insurance was also raised by many respondents. Some called on the Government to provide incentives, such as tax concessions, to people to encourage them to take out medical insurance. Many commented that at present, medical insurance products being offered in the market were too varied and lacked regulation. They also noted that people who were aged over 60 or 65, patients with chronic illnesses or those with pre-existing health risks were not able to obtain medical insurance cover.

(B) Others

29. Many views were received either on existing healthcare services or areas not covered in the Discussion Paper, some examples (not exhaustive) are as follows -

(i) Introduce penalty for those who defaulted medical payments;
(ii) Regulate use of public medical facilities by non-Hong Kong residents;
(iii) District Councils to be tasked to raise funds for district hospitals;
(iv) Improve the complaint system within the public health service;
(v) Long queuing time for general or specialist outpatient services;
(vi) Separation of drug prescription and dispensing; and
(vii) Enhancing dental services and services for mental patients.

CONCLUSION

30. We are grateful to the valuable views and suggestions from respondents. We wish to stress that the reforms raised in the Discussion Paper are conceptual outlines of a desirable future healthcare system for Hong Kong. We would need further thoughts to flesh out the implementation details and map out changes required at different fronts in order to realize the future service delivery model. Some recommendations will take more time to materialize, such as encouraging the private and social service sectors to develop a new type of short-stay institutions to provide temporary convalescent and rehabilitation services

and the training of more Community Nurses. Others would have resource implications on the part of stakeholders, for example, changing the licensing conditions of RCHEs to require them to engage medical doctors to take care of their residents' medical needs on a regular basis. The resource requirements and implications will have to be worked out prior to implementation. For those recommendations that can be taken forward in the near future, we will review the progress closely to ensure that there is no unnecessary delay. In the process, we will draw in the relevant parties and professions, including HA, DH, the medical professions, allied health groups, other primary healthcare specialists, the welfare sector and the NGOs and other relevant Government and non-Government bodies, to work together towards our desired model.

31. With regard to healthcare financing, the HMDAC has formed a working group in October to explore possible options with a view to putting forth recommendations for public discussion in the first quarter of 2006. We will forward the views received during the public consultation on this aspect to the Working Group for their consideration.

32. We would report to this Panel from time to time on progress made in relation to reforms made in the various healthcare service areas.

Health, Welfare and Food Bureau

December 2005

Annex A

List of briefing/consultation sessions on the Discussion Paper "Building a Healthy Tomorrow"

	Date	Briefing/Consultation Session
1.	19.7.2005	Legislative Council Panel on Health Services
2.	19.7.2005	Advisory Boards and Committees of the welfare sector
3.	21.7.2005	District Council Chairpersons and Vice-chairpersons
4.	21.7.2005	Hong Kong Academy of Medicine
5.	22.7.2005	Doctors' Associations and Academics
6.	25.7.2005	Staff members of Hospital Authority
7.	27.7.2005	Representatives of Nurses and Allied Health Associations
8.	9.8.2005	Joint Office of the Hong Kong Federation of Trade Union's Legislative Councillors
9.	16.8.2005	Patient Groups' Representatives
10.	17.8.2005	Public Consultation Session at City University
11.	18.8.2005	Public Consultation Session at Leighton Hill Community Hall
12.	3.9.2005	Hong Kong Medical Association
13.	5.9.2005	Hospital Authority New Territories Regional Advisory Committee Meeting
14.	6.9.2005	Serra Club's General Meeting
15.	8.9.2005	Meeting of the Kwai Tsing District Council
16.	13.9.2005	Meeting of the Wong Tai Sin District Council
17.	20.9.2005	Hospital Authority Kowloon Regional Advisory Committee Meeting
18.	20.9.2005	Meeting of the Wan Chai District Council
19.	22.9.2005	Hospital Authority Hong Kong Regional Advisory Committee Meeting
20.	24.9.2005	Seminar organized by the Office of the Hon. Legislative Councillor Dr. Kwok Ka-ki
21.	24.9.2005	Seminar organized by the Central District Kai-Fong Welfare Association Ltd.
22.	26.9.2005	Elderly Commission
23.	27.9.2005	Seminar organized by Chinese Grey Power
24.	27.9.2005	Meeting of the Tsuen Wan District Council
25.	28.9.2005	Hong Kong Council of Social Services – Seminar on Future Service Delivery Model

26.	29.9.2005	Hong Kong General Chamber of Commerce – Town Hall Forum
27.	4.10.2005	Seminar organized by the Hong Kong Paediatric Foundation and The Boys' and Girls' Clubs Association of Hong Kong
28.	5.10.2005	Public hearing organized by the Offices of the Hon. Legislative Councillors Ronny Tong Ka-wah, SC and Lau Kong-wah, JP
29.	6.10.2005	Meeting of the Central & Western District Council
30.	8.10.2005	Seminar organized by the Office of the Hon. Legislative Councillor Dr. Kwok Ka-ki
31.	16.10.2005	Hong Kong Doctors Union – Sunday Afternoon Symposium
32.	18.10.2005	Meeting of the Shamshuipo District Council
33.	22.10.2005	Seminar organized by the Salvation Army Yaumatei Integrated Service for Young People
34.	23.10.2005	Seminar organized by the Society for Community Organization
35.	25.10.2005	Meeting of the Kwun Tong District Council Social Services Committee
36.	27.10.2005	Meeting of the Yuen Long District Council
37.	28.10.2005	Forum on Medical Reforms by Medical Society, Hong Kong University Student Union
38.	29.10.2005	Working Group on Medical Services of Tuen Mun District Council Social Services Committee
39.	31.10.2005	Hong Kong Development Forum

Annex B

Public Affairs Forum

Summary of Comments on "Building a Healthy Tomorrow"

Forum members posted a total of 77 messages. The findings are listed below.

General Views on the Discussion Paper

- Many members agreed that the sustainability of our health care system needed to be addressed. They generally expressed support for the principles and direction set out in the discussion paper and in particular, they shared the view that the system must take care of the low-income and under-privileged groups.
- Only one member considered the proposed changes too revolutionary and more incremental changes should be adopted.
- Many members expressed that the changes would inevitably increase the financial burden on the middle class. As they are already the main contributor to income tax, they considered it unfair to require them to shoulder heavier financial responsibilities but at the same time reduce the services to be provided to them. A few also expressed worries about the drain on their resources when they have to treat major illnesses and considered that an equitable system for all rather than for only the low income groups should be devised.
- A few members commented that the paper lacked a clear description of concrete implementation plans and cast doubt on whether the future service delivery models could be achieved and at affordable prices.
- A number of members opined that traditional Chinese medicine could contribute to disease prevention and maintenance of health but the role and contribution of Chinese medicine have not been covered in the paper. They urged for the inclusion of Chinese medicine in the future service delivery model.
- A member stated that mental health problems have become

increasingly serious but the discussion paper has not covered mental health care. It was considered that sufficient resources should be allocated to provide good community care for discharged mentally ill persons.

- A member stated that the paper lacked elaboration on the long term manpower plan in conjunction with the reform initiatives.

Views Expressed on Specific Service Areas

Primary Medical Care Services

- The majority of members supported the concept of strengthening primary health care and preventive care and the promotion of family doctors.
- Nevertheless, a few members questioned whether there would be sufficient qualified family doctors and cast doubt on the feasibility of implementing the concept.
- A number of members expressed worries on whether family doctors would be costly and not affordable by the general public.
- Many members pointed out that the concept is new and it would be necessary to change the mindset of the public. It was suggested that vigorous publicity and educational campaigns should be organized to arouse public awareness and promote the concept of family doctors.
- Furthermore, concerted efforts with other allied health professionals, patient groups, non-governmental organizations, schools, media etc. should be made to educate citizens to take responsibility for their own health and develop a healthy lifestyle on a long term basis.
- A few members considered that incentives and training would be needed to induce private doctors to change and implement the family doctor concept.
- There were a few suggestions on providing regular health check-up for the elderlies particularly those who could not afford to use private sector service.

- A member expressed support for the free flow of patients' record but cautioned that the privacy and right of access to personal data should be carefully examined.

- A member concurred with the idea of establishing a platform on a regional/district basis to facilitate collaboration among medical and other professionals. It was considered that the establishment should have high transparency and be empowered to oversee, manage and review the implementation of medical reform in the respective districts.

Hospital Services

- Many members expressed that the inappropriate use of A & E and ambulance services have exacerbated the stringent financial condition of the Hospital Authority (HA) and suggested that the related fees and charges should be increased to reduce abuse.

- A few members suggested some measures to induce the public to use private medical services instead of A&E services, namely, the provision of subsidy to patients; the offer of rental subsidy to facilitate the establishment of private clinics near to hospital; the separation of the cost of medication and consultation to lower the fees of private doctors.

- Some members expressed that the accessibility to medical services by non-Hong Kong residents should be tightened to reduce abuse and the related fees and charges be increased to recover costs.

- As patients generally lack the professional knowledge to determine whether their cases require emergency care, a member expressed concern about possible delay for emergency treatment if the patients were to consult family doctor first under the future model.

- A few members opined that public and private hospitals should perform different roles and provide different levels of medical services: the former to provide just the standard and essential services for all; the latter to provide more luxurious services for those who could afford and services not critical to live and death.

Tertiary and Specialised Services

- A few members expressed support for the proposal to increase the patient co-payment portion as they considered that this is in line with the user-pay principle. However, there was concern that the proposal to apply a cap on the percentage of the patient's income and assets for the co-payment would create unfairness.

Elderly, Long Term and Rehabilitation Care

- A few members expressed support for the concept of shifting health care from hospital-based to community-based.
- They generally considered that more nurses should be trained and that the Community Nurse Service and Outreach Medical Team with the support of other health care professionals should be expanded to strengthen the support and scope of services of community care programmes.

Collaboration between the Public and Private Sectors

- A few members expressed support for the direction towards more public private collaboration.
- However, they were generally concerned about the hefty fees of the private sector and the lack of transparency in the fee charging system. They urged for more stringent regulatory measures to improve the situation and to ensure the quality of services.

Views Expressed on Health Care Financing

- Considerable members commented that there was inefficiency in the public health care system and called for cost containment and

streamlining of the organization structure of the HA to enhance efficiency.

- A number of members concurred with the adoption of the user-pay principle but stressed that this must be supported by a safety net to cater for the low-income and under-privileged groups and those with catastrophic illnesses.

- A few members commented that the existing fees are far too low and supported an increase of fees and the charging of different levels of fees having regard to affordability.

- Considerable members suggested the use of medical insurance to address the long term health care financing problem and to drive for better quality medical services as the money will follow patients. A few of them considered that medical insurance scheme should be mandatory so that all would share the responsibility of funding the health care system.

- A few members pointed out it would be necessary to devise insurance schemes which could cater for different income groups and patients with varying medical needs.

- A member considered that if medical insurance were to be implemented, it would be important for government to ensure the solvency of the insurance companies and also prevent them from exerting influence on doctors on the use of drugs and treatment.

- A member expressed objection to the introduction of mandatory levy for a medical fund having regard to the fact that administrative charges have to be paid irrespective of investment outcome, and the contribution made could not directly benefit the concerned individual.

- Many members suggested the provision of tax incentives to induce the public to use private hospital services and to take out medical insurance. A member proposed to offer tax encouragement for those who take care of long-term patients at home.

- A few members considered that the tax base should be broadened and suggested the introduction of sales tax to share out the tax burden amongst those who could afford to pay.

- A few members suggested the allocation of tax on certain commodities which directly affected health (e.g. tobacco, alcohol) to fund health care expenditure.

- A few members considered that ways to allow funding to follow patients (e.g. medical voucher) should be explored.

- Some suggestions to reduce the cost of provision of medical services were proposed by a number of members. This included the establishment of nurse clinics to provide primary care services with minimal medical professional attendance; the establishment of private polyclinics to reduce overhead cost; delivering health education by nurses and at school; making use of technology to enable real time monitoring of patients (with chronic illnesses) medical data at home to reduce their need for admission into hospital; collaboration with property management agencies to establish a comprehensive network of disease surveillance and disease prevention in the local community; training and deployment of property attendants to provide simple basic assistance to the elderly and patients at home; allowing experienced doctors of HA to work in the private sector and contributing part of the income to HA.

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