For discussion on
16 October 2009

Legislative Council Panel on Health Services
Policy Initiatives of Food and Health Bureau

Purpose

This paper elaborates the new initiatives and progress of on-going initiatives in respect of health matters as set out in the 2009-10 Policy Agenda.

New Initiatives

Allocating additional resources and establishing a dedicated team to implement the initial recommendations of the Working Group on Primary Care in the next few years

2. The proposal to enhance primary care as set out in the Healthcare Reform Consultation Document "Your Health, Your Life" in 2008 received broad public support. Primary care is the first point of contact for individuals and families in a continuous healthcare process. Good primary care provides the public with access to comprehensive and holistic care, with an emphasis on disease prevention and betterment of health. To take forward the primary care reform initiatives as set out in the Healthcare Reform Consultation Document, the Secretary for Food and Health (SFH) appointed and led the Working Group on Primary Care (WGPC) in end 2008 comprising representatives of public and private healthcare professionals, patient groups etc.

3. Three task forces, comprising healthcare professionals, patients' representatives and other stakeholders, have been set up under the WGPC to:

(i) develop conceptual models and clinical protocols for primary care;

(ii) set up and promote a Primary Care Directory; and

(iii) design feasible service delivery models, based on the conceptual models and clinical protocols for primary care, to enhance primary care services in the community.

4. After about one year's in-depth discussions, the WGPC has proposed initial recommendations on the above three areas of work in September 2009. We are now taking stock of the initial recommendations and developing concrete implementation measures. We plan to publish a primary care strategy paper for consultation and promotion next year. We also plan to establish a joint dedicated team comprising representatives of the Food and Health Bureau (FHB), Department of Health (DH) and Hospital Authority (HA), and allocate additional resources to the team to implement the above recommendations, coordinate the future development of primary care in Hong Kong and support the future work of WGPC. The relevant work plans are outlined below —

(i) Developing and promoting protocols for managing individual chronic diseases

5. Chronic disease have become more prevalent owing to the ageing population coupled with changes in lifestyles. This not only affects people's state of health, but also places significant pressure on our healthcare system. Common chronic diseases can be effectively managed through provision of holistic, comprehensive and continuous primary care services with emphasis on preventive care by cross-sector and multi-disciplinary collaboration. In light of the recommendations of the WGPC, we will develop conceptual models and clinical protocols for different chronic diseases and age/gender groups based on family medicine principles and the public health approach. These models and protocols will provide benchmarks for comprehensive primary care services, and will guide and coordinate the efforts of different professions to develop and enhance the strategy for managing common chronic diseases at primary care level.

6. As the first step, we are now working on the clinical protocols for hypertension (HT) and diabetes mellitus (DM), the two commonest chronic diseases in Hong Kong, for common reference by different healthcare sectors. We are collecting views from healthcare professionals on the draft conceptual models and clinical protocols. In addition, we will draw up strategies for promoting the conceptual models and clinical protocols to enhance their understanding and adoption by the public and healthcare professionals, and to raise their awareness of HT and DM and improve the prevention and management of the two diseases. As a next step, we will proceed to develop

conceptual models and clinical protocols for other common diseases/ age-group specific health problems.

(ii) Development and promotion of a Primary Care Directory

7. We will also develop a Primary Care Directory to inform the public and healthcare personnel of the professional qualifications and practice-related information of primary care personnel. This will help members of the public to seek appropriate primary care services in the community, promote the family doctor concept and care model and facilitate the teaming up of primary care healthcare professionals for the provision of more comprehensive primary care services.

8. According to the recommendations made by the WGPC, we will develop the Primary Care Directory by phases. We will first work on the sub-directories on western medical practitioners and dentists, and then on the sub-directories on Chinese medicine practitioners, nurses and other allied health professionals. We are discussing with healthcare professionals on the requirements for healthcare personnel to be included and continue to be listed in the Directory in respect of their professional qualifications, experiences and training received; the long-term development of the Directory, including further enhancement of the related professional requirements for future listing in the Directory; and issues such as training and manpower development of primary care professionals. We will also develop strategies for promoting the Directory to healthcare professionals and the public so as to increase their understanding and use of the Directory with a view to further developing and reinforcing long-term partnership between individuals and primary care providers as well as a team approach in providing primary care in the community.

(iii) Designing and testing various primary care service delivery models

9. In light of the recommendations of the WGPC, we are working with healthcare professionals on different appropriate models for delivery of comprehensive and continuous primary care services and on the incentives for promoting the primary care services provided based on the new conceptual models and clinical protocols, including enhancement of management for HT and DM. In formulating the primary care service delivery models, we will take into consideration the needs of different target groups and communities as well as the current healthcare system and modes of service delivery, in particular the

feature that public sector, private sectors and other non-governmental organisations (NGOs) are all providing primary care services at present.

10. In the coming three years, we will continue to join hands with the public and private healthcare sectors and/or NGOs to launch a number of pilot projects to enhance primary care services and support chronic disease patients. Some of the pilots have already been rolled out (see paragraph 29 below). In light of WGPC's study and recommendations on the "community health centre" concept as proposed in the last Policy Address, we plan to launch pilot projects in various districts to set up community health centres and networks under different models of participation and partnership among the public and private healthcare sectors as well as NGOs, so as to provide more comprehensive one-stop primary care services to patients.

11. In addition to the implementation of the recommendations of the WGPC, we will introduce the following seven new initiatives in the coming year –

(I) Introduction of a subsidy scheme for elderly to receive seasonal influenza and pneumococcal vaccinations

12. At present, the Government provides free seasonal influenza vaccination to target groups annually at public hospitals or clinics under the "Government Influenza Vaccination Programme" (GIVP). To reduce the risk of seasonal influenza and pneumococcal infections, we will further introduce a series of seasonal influenza and pneumococcal vaccination programmes in 2009-10. Specifically, the existing GIVP will be extended and renamed as the "Government Vaccination Programme" (GVP), under which seasonal influenza and pneumococcal vaccinations will be provided to all eligible elders aged 65 and above.

13. For elderly aged 65 and above who are not on the GIVP, they can receive subsidized seasonal influenza and pneumococcal vaccinations at private practitioners' clinics through the newly launched "Elderly Vaccination Subsidy Scheme" this year. Under the scheme, the cost of vaccines and injection fees are subsidized. The subsidies to the costs of seasonal influenza vaccines and pneumococcal vaccines are HK$80 and HK$140 per dose respectively, and the subsidy for injection fee is HK$50. The Government will reimburse the subsidies for the vaccine costs and injection fees to private practitioners

participated in the scheme directly, and encourage them not to impose any other charges to the elders.

(II) Provision of human swine influenza (HSI) vaccination for high risk groups

14. For the purpose of safeguarding public health, the Government will provide HSI vaccination to target groups of the population before the winter peak of seasonal influenza in 2009-10. The vaccination is voluntary in nature. The DH has initiated the process for procurement of the vaccines and is working on the implementation details of the vaccination programme. Details of the programme will be announced in due course.

(III) Promoting the development of private healthcare

15. As part of the healthcare reform initiatives, we will strengthen the hardware and software support to actively promote and facilitate the development of private healthcare services, with a view to increasing the overall capacity of the healthcare system in Hong Kong and addressing the imbalance between the public and private sector. This will also help Hong Kong develop and consolidate its position as a regional centre of medical excellence. For hardware, we have reserved four sites (at Wong Chuk Hang, Tseung Kwan O, Tai Po and Lantau respectively) for the development of private hospitals. The Government will launch an Expression of Interest exercise by end 2009 to solicit market interest in developing private hospitals in the four reserved sites. We will make appropriate land disposal arrangements in light of the market response. We will ensure that the conditions of land disposal are fair to the private hospitals and the public, and that the development of private hospitals will promote the expansion of the medical services industry and enhance our health services to benefit the community. As for the support in software, we will continue to enhance training for healthcare professionals; create a favourable environment to attract healthcare talents from overseas; and strengthen exchanges, research and training of healthcare personnel with a view to further enhancing the professional standard of our healthcare sector.

(IV) Conducting the second-stage public consultation on various healthcare reform issues and concrete proposals on healthcare financing

16. As revealed in the first-stage public consultation on healthcare reform conducted early last year, there is a broad consensus in the community for implementing the healthcare reform without delay so as to enhance our healthcare services and ensure the sustainable development of our healthcare system. We have adopted a multi-pronged and incremental approach in our healthcare reform implementation. We are honouring the pledge to increase progressively the health budget from 15% to 17% of the Government's recurrent expenditure. Meanwhile, we have been taking forward the healthcare reform measures which have received wide public support, including the enhancement of primary care reform, promotion of public-private partnership in healthcare and development of a territory-wide electronic health record sharing system. We will also strengthen the safety net of our public healthcare services so as to give better protection for patients requiring costly drugs and treatment.

17. Based on the views collected in the first-stage public consultation, we are formulating specific proposals on the following three issues on the healthcare reform and planning for the second-stage public consultation in 2010 –

(i) Strategy for the development of primary healthcare services

18. As mentioned in paragraph 2 above, the WGPC led by SFH has made initial recommendations to enhance primary healthcare services. Based on these recommendations, we will map out the future overall development strategy and specific implementation measures for our primary healthcare services in accordance with the work plans set out in paragraphs 5-10 above. They will be made known to the public, healthcare professionals and various stakeholders for further consultation and promotion in 2010.

(ii) Electronic Personal Health Data Privacy

19. The Finance Committee of the Legislative Council approved a commitment of $702 million for implementing the first stage of the Electronic Health Record (eHR) Development Programme (from 2009-10 to 2013-14) on 10 July 2009. This territory-wide patient-oriented system connecting the public and private healthcare providers is one of the key elements for

implementing the healthcare reform. Through connecting the patients and different healthcare service providers, the eHR system will become an essential infrastructure for enhancing primary care and facilitating public-private partnership.

20. We recognise the concern of stakeholders and the public over the data privacy and security of the eHR sharing system. In this connection, we will consult the relevant professions, stakeholders and the public in 2010 on issues such as voluntary participation, authorisation and consent for record access and the long-term legal framework required for the protection of privacy and security of personal health data, and prepare for the drafting of the necessary legislation.

(iii) Healthcare financing

21. The first-stage public consultation on healthcare reform conducted last year reflected clearly a broad recognition among the public that that our ageing population will result in significantly increased healthcare expenditure, and hence there is a need to address the issue of healthcare financing. That said, the public have expressed reservations on various mandatory options of supplementary healthcare financing proposed in the consultation paper, be they tax increase, social health insurance or mandatory insurance/savings. Moreover, many members of the public favour voluntary medical insurance and consider that it could have a bigger role to play with enhanced government regulation and supervision.

22. Taking into account the views collected in the first-stage public consultation, we are now working on a medical insurance and savings scheme which will be standardized and regulated by the Government and participated by the public and employers on a voluntary basis. The $50 billion set aside for the healthcare reform will be used to provide subsidies for people who participate in the scheme. This option will enable a wider choice of private healthcare services for those who are able to afford by using regulated voluntary health insurance schemes. This will in turn ease the pressure on the public healthcare system and benefit people in need of public healthcare services. We are now working on the details and will consult the public on the proposal next year.

23. In the long run, after the supplementary financing option has been implemented for a period of time, we will review the arrangements of the

scheme with a view to making the scheme more effective in facilitating the sustainable development of our healthcare system.

(V) Enhancing mental health services to better cater for the needs of various mental patients

24. We have been closely monitoring the utilization of mental health services and have set up the Working Group on Mental Health Services (Working Group) to help review the existing service in order to consider making appropriate service adjustment or improvement. In the past few months, the expert groups under the Working Group have conducted preliminary studies on the service needs of various target groups. They have affirmed the importance of early identification and treatment as well as the service direction of enhancing community for patients. To further improve mental health services, they have also suggested that the Government adopt appropriate service strategies according to the needs of patients and to provide them with the appropriate support. Having considered the views of the Working Group and its expert groups, we will launch two new initiatives through HA in 2010-11 to enhance the support for persons with severe mental illness and persons with common mental disorders respectively –

(i) Launching a case management programme to provide intensive community support to persons with severe mental illness

25. HA will pilot a case management programme in individual districts and train up healthcare staff as case managers to provide continuous and personalized intensive support to persons with severe mental illness. Under the programme, the case manager will establish a long-term and close service relationship with the patients and their family members in order to better understand the needs of the patients, including treatment, rehabilitation and other daily needs. The case managers will then coordinate and arrange for the patients to receive various services. Also, the case manager will establish linkages with the mental health service providers of the social welfare sector through the Integrated Community Centres for Mental Wellness to be set up by the Social Welfare Department in various districts in 2010-11. The purpose is to arrange one-stop social rehabilitation services for patients in need and to further enhance the collaboration between the medical and social welfare service systems. Depending on the effectiveness of this new service model and the manpower arrangements, HA will gradually expand the programme across the

territory in the coming three years. It is expected that the number of patients benefited will increase from 5,000 in 2010-11 to 16,000 in 2012-13.

(ii) Enhancing the assessment and treatment services for people with common mental disorders

26. To better cater for the treatment needs of people with common mental disorders, HA will foster closer collaboration between its psychiatric specialist outpatient service and primary care service in order to provide patients with the appropriate assessment and treatment services. HA will strengthen the assessment services for people with common mental disorders and focus on taking care of patients with complex needs at its specialist outpatient clinics. At the same time, HA will refer patients with milder conditions for further follow-up by its primary care service. HA will also provide support to its primary care service in the delivery of integrated mental health care to these patients with a view to relieving their conditions as early as possible and enhancing their chance of recovery. It is expected that 10,000 patients will be benefited under this new initiative in 2010-11 and the number of patients benefited will increase to 20,000 in 2012-13.

(VI) Completing the review on the regulation of pharmaceutical products in Hong Kong

27. In the light of the drug incidents in early 2009, we have set up a Review Committee on Regulation of Pharmaceutical Products in Hong Kong to undertake a comprehensive review of the existing regulatory regime for pharmaceutical products. Our aim is to step up the control on supply of drugs and enhance the standard and performance of the pharmaceutical sector for the purpose of ensuring patients' safety and safeguarding public health. The scope of the review includes the updating of the Good Manufacturing Practices scheme, enhancement of pharmacovigilance in drug manufacturing, strengthening of the pharmaceutical sector's governance and internal audit system, stepping up regulatory control of the drug distribution, updating of the licensing requirements and penalty system, reviewing the procurement and supply of drugs in public and private healthcare sectors, and strengthening training and education of those in the trade. The review is in progress and will be completed by end 2009. Legislative amendments will be proposed where necessary.

(VII) Promoting the development of Chinese medicine in Hong Kong

28. To further promote the development of Chinese medicine in Hong Kong, the Government has strived to develop standards for Chinese herbal medicines. The Government has also strengthened the regulation of Chinese medicine traders and proprietary Chinese medicine in accordance with the relevant provisions under the Chinese Medicine Ordinance. The DH has conducted studies on the development of standards for Chinese herbal medicines since 2001. Support and advice have been received from Mainland and overseas experts and local universities. Our target is to study and develop standards for around 200 Chinese herbal medicines. We have now completed the studies on the standards for 60 commonly used Chinese herbal medicines in Hong Kong and will continue to develop standards for the remaining ones. We hope that this can ensure the safety and quality of Chinese medicines and help lay a solid foundation for scientific research and facilitate the development of Chinese medicine.

On-going Initiatives

To enhance support for the management of chronic diseases

29. In last year's 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. 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 programmes for high-risk patients, helping chronic patients improve their self-care skills through enhanced education and subsidising chronic patients to choose receiving comprehensive treatment from private practitioners. We are, through the HA, rolling out the following pilot projects to provide support for chronic patients –

(i) Multidisciplinary Risk Factor Assessment and Management Programme

30. Multidisciplinary teams of professional healthcare personnel including nurses, dieticians and pharmacists are set up to provide comprehensive health risk assessment for HT and DM patients of public clinics so that they can receive appropriate preventive and follow-up care. The HA has implemented the programme on a pilot basis in designated general out-patient clinics (GOPCs)

in the Hong Kong East and New Territories East hospital clusters and will extend the programme to the seven clusters across the territory by phases in the coming three years.

(ii) Patient Empowerment Programme

31. A pilot patient empowerment programme will be developed and launched in collaboration with NGOs to raise chronic patients' awareness of the diseases and enhance their self-care ability. Under the programme, a multi-disciplinary team comprising allied health professionals from the HA will develop appropriate teaching materials or aids for various types of common chronic disease (e.g. HT, DM, etc.) and provide training for the frontline staff of the participating organisations. The HA is preparing the tender exercise and it is expected that the programme will be introduced in the first quarter of 2010.

(iii) Nurse and Allied Health Clinics

32. Nurse and Allied Health Clinics comprising nurses and allied health practitioners will be established to follow up on the cases of high-risk chronic patients including those who require specific care services or are suffering from certain complications. The HA has started to launch a pilot scheme in selected GOPCs in its seven clusters to 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 patients according to their conditions; and

(iv) Public-Private Shared-Care Programme for management of chronic diseases

33. In the coming three years, a subsidisation programme will be implemented in two of the clusters under the HA, under which HT and DM patients who are being followed up in the public specialist out-patient clinics p can choose to have a private doctor to follow up on their conditions and receive a package of comprehensive care services jointly provided by both the public and private sectors. Private doctors participating in the programme are required to provide care services to patients in accordance with the protocols developed by the WGPC. Patients can participate in the three support programmes in items (i)-(iii) above upon referral. In the event that patients develop complications or other problems and require assessment by specialists,

the private doctors can refer the patients back to the public Specialist Out-patient Clinics for early follow-up as appropriate. We are now working on the details of this programme including patients' eligibility criteria, patients' health indicators, mode of subsidisation, referral mechanism, etc. We plan to launch this programme on a pilot basis in early 2010.

34. In the initial period of implementation, the above pilot programmes will target at chronic patients under the care of the HA. We will assess the effectiveness of the pilot programmes and consider extending them to cover chronic patients receiving private healthcare having regard to the assessment results and experience from the programmes.

Elderly Healthcare Voucher Pilot Scheme

35. The Elderly Healthcare Voucher Pilot Scheme has been launched on 1 January 2009 for three years up to the end of 2011. The Scheme, through the provision of partial subsidy, aims at implementing the "money-follow-patient" concept on a trial basis. This is to enable the elderly to choose within their local communities the private primary care services that best suit their needs, thereby enhancing the primary care services for the elderly and piloting a new model for subsidising primary care services in the future. As at 13 October 2009, over 170,000 elders aged 70 or above have created their healthcare voucher accounts and more than 2,400 healthcare service providers have enrolled in the Pilot Scheme. These service providers include western medical practitioners, dentists, Chinese medicine practitioners, chiropractors, registered nurses and enrolled nurses, physiotherapists, occupational therapists, radiographers and medical laboratory technologists, from all 18 districts in the territory. We will conduct an interim review after the Scheme has been implemented for a year. A comprehensive review will also be carried out upon the completion of the three-year pilot period. The reviews will cover the effectiveness and scope of the Scheme, amount of subsidy, etc.

Construction of Tin Shui Wai Hospital

36. We consulted the Yuen Long District Council (YLDC) on the Tin Shui Wai Hospital project and the site selection in March 2009. Members of YLDC supported the plan to build the hospital and agreed that relevant technical assessments and studies (including traffic impact assessment and environmental impact assessment) should be conducted on the proposed site (Area 32 of Tin

Shui Wai) before deciding on the hospital site. Relevant technical assessments are being conducted. We plan to further consult YLDC on the site selection for the hospital by end 2009 upon completion of the relevant assessments. If the site selection and project planning are supported by YLDC, we will commence the tendering procedures for the project and work out the project estimate based on the tender price. After that, we will consult the Legislative Council and seek funding approval for the project. We plan to seek funding approval from the Legislative Council in late 2011/early 2012 and to complete the construction works in 2015.

Preparing for the establishment of multi-partite medical centres of excellence in paediatrics and neuroscience

37. The FHB has set up steering committees for the development of medical centres of excellence in paediatrics and neuroscience respectively. The Steering Committees, chaired by the Permanent Secretary for Food and Health (Health), comprise experts in paediatrics and neuroscience from both the public and private medical sectors and the academia, as well as representatives from relevant professional medical organisations, allied health groups and patients' groups.

38. The Steering Committees have agreed that the two centres, which will bring together medical professionals in the public, private and overseas medical sectors, should provide specialist care services for patients suffering from complex illnesses and conduct research and training. As for the management and financial arrangements of the two medical centres, there should be a breakthrough from the existing practices generally adopted by the public or private hospitals, and emphasis should be put on multi-partite collaboration, with a view to achieving excellence in service, research and training. Views have been collected from various stakeholders, including the healthcare personnel and allied health professionals in both public and private healthcare sectors, patients' groups, patients and their families. The Steering Committees have also reached an initial consensus on the scale, facilities and areas of the two centres, and recommended that the centres should be centrally located, easily accessible and in close proximity with a general hospital. The Steering Committees and their working groups will continue to look into all relevant issues of the two centres, including the clinical, research, training and physical infrastructure requirements, the governance framework, and the financial and manpower arrangements.

39. The Administration is studying the siting and the technical feasibility of the two medical centres of excellence, taking into account the requirements on the scale and facilities of the centres as set out by the Steering Committees. Upon completion of the study, we will seek funding support from the Finance Committee of the Legislative Council.

Enhancing public healthcare services through public-private partnership

40. We will continue to provide healthcare services through various modes of public-private partnership. This is to make better use of resources of the private healthcare sector for provision of more cost-effective healthcare services which meet the required quality standard, offer additional choices for patients in their use of subsidised public healthcare services and shorten waiting time for public healthcare services. To this end, we will continue to implement the following initiatives –

(i) Purchasing haemodialysis service from private centres for end stage renal disease patients currently under the care of public hospitals

41. Currently, end stage renal disease (ESRD) patients followed up by the 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. We will, through the HA, launch a three-year pilot project under which ESRD patients followed up by the HA will be given a subsidy to receive HD services provided by private practitioners or NGOs. The HA will continue to provide specialist out-patient services, drugs and laboratory services to patients participating in the project. They can also keep their place on the HA's organ transplant waiting list. The HA is now preparing for the tendering of the project. It is expected that the project will commence in early 2010.

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

42. The HA launched a three-year pilot project in TSW North in June last year, allowing chronic patients in stable conditions and in need of long-term follow-up treatment at GOPCs to voluntarily participate in the pilot project and receive treatment from participating doctors practising in the district. The HA

will pay fees to participating doctors in accordance with the service contract while participating patients are only required to pay the same fee as charged by GOPCs. The project aims to strengthen the public general out-patient services in order to address the increasing service demand and enhance the medical care rendered to the chronic disease patients. As at end September 2009, six practising private doctors in TSW North (over one-third of the private clinics in TSW North) and over 1,100 patients have participated in the pilot project. We plan to expand the project to TSW South to benefit more chronic patients followed-up at GOPCs. With the relief of the pressure on general out-patient services, the low-income families and the under-privileged in need of such services will also be benefited.

(iii) Cataract Surgery Programme

43. HA piloted a Cataract Surgery Programme through public-private partnership since February 2008 to allow eligible patients to choose to receive cataract surgeries either in the private sector or in public hospitals. The programme on one hand provides subsidy to patients who choose to receive surgeries in the private sector and on the other increases the number of surgeries conducted in public hospitals so as to reduce the waiting time for cataract surgeries in public hospitals. So far, more than 5 400 patients have successfully received surgeries and restored their eyesight under the programme. HA is now conducting initial review on the programme and will consider extending the progarmme to benefit more patients.

Continuing to develop a territory-wide patient-oriented electronic health record system

44. The FHB set up the eHR Office in July this year to take forward the territory-wide patient-oriented eHR Programme for sharing important health and medical records of patients between healthcare providers subject to the patients' consent and providing an essential infrastructure for implementing healthcare reform. Our initial target is to have the eHR sharing platform ready by 2013-14 for connection with all public and private hospitals, and to ensure the availability of electronic medical/patient record and other health information systems in the market for private doctors, clinics and other healthcare service providers to connect to the eHR sharing platform. To address the issue of personal data privacy arising from the development of the sharing system and to ensure adequate protection for personal data in the system, the eHR Office will,

in collaboration with the Office of the Privacy Commissioner for Personal Data, conduct a "Privacy Impact Assessment" in early 2010 and implement a "Privacy Compliance Audit" upon individual components of the system commencing operation. As the integrity and security of the eHR sharing system are crucial to protect the interests of both patients and healthcare service providers and to enhance confidence in the system within the community, the eHR Office will conduct a "Security Risk Assessment" and a "Security Audit" in collaboration with the Office of the Government Chief Information Officer in respect of the whole eHR Programme and individual development designs and projects. The eHR Office will, based on the findings of the assessments, make adjustments to the system as appropriate.

45. One of the key elements of the eHR Programme is the participation of stakeholders in the private and non-government sectors. In this connection, the eHR Office has recently launched the first stage of the Electronic Health Record Engagement Initiative (EEI) and invited all private and non-government organisations providing health-related services to submit proposals on the possible partnership projects on eHR development. Private healthcare service providers can also submit joint proposals in collaboration with IT service vendors. The EEI is the first step taken by the eHR Office to engage different healthcare service providers in the early stage of the development of the eHR sharing system. The eHR Office will implement the partnership projects in phases and conduct an interim review to develop an appropriate strategy to further promote eHR sharing among stakeholders in the private sector and the public.

Further expanding the "Electronic Patient Record Sharing Pilot Project"

46. We will collaborate with the HA in further expanding the "Electronic Patient Record Sharing Pilot Project" (PPI-ePR) to allow more private healthcare providers, including those participating in public-private partnership projects, to access their patients' medical records kept at the HA and input the patients' clinical information upon the patients' consent, with a view to promoting sharing of patients' records and preparing for the participation of the private sector in the eHR sharing system in future. Over the past year, PPI-ePR has enrolled over 74,000 patients, 1,400 private healthcare professionals, 12 private hospitals, 10 other private and non-government organisations providing healthcare-related services, and more than 40 institutions. PPI-ePR has received positive feedback from both participating patients and healthcare

providers. We will continue to expand the one-way sharing pilot project to the DH and more private and non-government organisations, to allow more patients and private healthcare providers to try out eHR sharing. Since January this year, we have also tested the two-way sharing technologies through the Radiological Image Sharing Pilot that allows private healthcare providers to send radiological images to the HA via electronic means with the consent of patients. The HA will continue to expand PPI-ePR to other interested private healthcare providers. Besides, we will also test the system security and data privacy protection measures and technologies through PPI-ePR and examine ways to tie in with the future territory-wide eHR sharing system, so as to minimise duplicate data for both systems.

Enhancing professional training for medical and healthcare practitioners

47. HA has all along attached great importance to the professional training and development of medical and healthcare practitioners. In recent years, it has implemented a series of initiatives to enhance their training and improve their working arrangements, including the establishment of the Institute of Advanced Allied Health Studies to provide systematic training to allied health practitioners; re-opening certain nurse training schools to train more nurses to meet the service demand; implementation of new career development structures for doctors, nurses and selected grades of allied health practitioners to enhance their training and the opportunities for development; allocation of additional resources to provide medical and healthcare practitioners with specialist training and short-term overseas training scholarships so as to enhance their professional competence and support the career development structure of their respective grades; and continuous implementation of the pilot programmes of the Doctor Work Reform and measures to improve the working arrangements of nurses. We will from time to time make assessment on the medium and long term manpower requirements of medical and healthcare practitioners to ensure that our public healthcare system can cope with the future needs.

Overseeing the implementation of the three-year interim funding arrangement for the HA

48. With an increase in overall healthcare demand arising from a growing and ageing population in Hong Kong, as well as rapid advancement in medical technology, the operating costs of the HA is ever-increasing. We have decided to provide an additional recurrent subvention of some $870 million per annum to the HA in the three-year period from 2009-10 to 2011-12 to strengthen

its services. To ensure the continuous provision of quality public healthcare services by HA, we will continue to monitor closely the service and operational needs of HA, oversee the implementation of the three-year interim funding arrangement, and work out a long-term and sustainable funding arrangement in the light of the outcome of public consultation on the healthcare reform.

Strengthening the regulation of Chinese medicine

49. The Chinese Medicine Ordinance gives statutory recognition to the professional status of Chinese medicine practitioners and is designed to ensure the professional standard and conduct of practitioners and those who are in the Chinese medicine industry. This will, in turn, enhance public confidence in Chinese medicine. We will continue to strengthen the regulation of Chinese medicine to foster its continuous development in Hong Kong. On the registration of proprietary Chinese medicines, the Chinese Medicines Board of the Chinese Medicine Council of Hong Kong issued the first batch of "notices of confirmation of transitional registration of proprietary Chinese medicine" in early 2008. As at September 2009, the work on the transitional registration of proprietary Chinese medicine has generally been completed. We plan to commence the operation in 2010 the remaining provisions under the Chinese Medicine Ordinance relating to mandatory registration of proprietary Chinese medicine, so as to further strengthen our efforts in the regulation of Chinese medicine.

Enhancing Chinese medicine service in our public healthcare system

50. During the past few years, the Government has been actively taking forward the plan to establish public Chinese medicine clinics (CMCs). So far, we have established 14 public CMCs, which are located in the Central and Western District, Wanchai, the Eastern District, Kwun Tong, Wong Tai Sin, Sham Shui Po, Tsuen Wan, Tai Po, Tseung Kwan O, Yuen Long, Tuen Mun, Kwai Tsing, the North District and Shatin respectively. We are now making an effort to identify suitable sites in Kowloon City District, the Yau Tsim Mong District, the Southern District and the Islands District for establishing four additional CMCs, so as to enhance Chinese medicine service in our public healthcare system.

Implementing the Prevention and Control of Disease Ordinance and continuing to improve our infectious disease surveillance, control and notification system

51. At present, the Prevention and Control of Disease Ordinance and its subsidiary legislation, namely the Prevention and Control of Disease Regulation, ensure that the laws of Hong Kong are in line with the requirements of the International Health Regulations (2005) of the World Health Organization and that our mechanism are effective in controlling infectious diseases and in coping with public health emergencies. In addition, the Centre for Health Protection (CHP) of the DH has also drawn up contingency plans to handle major infectious disease outbreaks and these plans are subject to reviews and updates on a regular basis. Besides, the DH has maintained close communication and collaboration with our neighbouring regions to cope with public health emergencies. In this regard, a joint drill involving the participation of the health authorities of the Mainland and Macao has been carried out annually since 2006 to test out the communication and emergency response mechanism of the three places. We will continue to improve our infectious disease surveillance, control and notification system, with a view to reducing the spread of infectious diseases in local communities to safeguard the health of our population.

Developing a multi-prong strategy to minimise the risk of avian flu outbreaks, including the development of a poultry slaughtering centre

52. We will continue to adopt a multi-sectoral approach with the healthcare, social welfare, education, property management, public transportation and tourism sectors to enhance our preparedness for avian flu and influenza pandemics. We will focus our efforts to reduce the risk of human infection, maintain a surveillance system for timely detection of human infection of avian flu, strengthen our emergency response capability and maintain collaboration with the Mainland and international health authorities. Furthermore, we will adopt proactive risk communication strategies and widely disseminate health information on seasonal influenza, avian flu and influenza pandemic preparedness as well as preventive and response measures through various channels.

Prevention and Control of Non-communicable Diseases

53. Non-communicable diseases (NCD) are major causes of ill-health, disability and deaths. In 2008, five major NCD, namely cancer, heart diseases, stroke, chronic lower respiratory diseases and diabetes, accounted for around two-thirds of all registered deaths in Hong Kong. Many NCD are the result of how we live our lives and our living habits, such as smoking, unhealthy diet, physical inactivity and excessive drinking.

54. To improve the population's health profile and reduce the burden of NCD, the DH drew up the "Strategic Framework for Prevention and Control of Non-communicable Diseases" (the Framework) in October 2008. This Framework sets out directions for controlling NCD and calls for concerted efforts in the control and prevention of NCD, which will help shape an environment that is conducive to the promotion of Hong Kong people's health and well-being. In addition, a steering committee chaired by the Secretary for Food and Health was established in October 2008 to oversee the development of the strategy as well as the progress of its overall implementation and way forward. Two working groups have been set up under the steering committee to make recommendations to the steering committee on diet and physical activity as well as injuries and alcohol misuse respectively.

Enhancing cancer surveillance

55. Cancer is the number one killer disease in Hong Kong. To prevent and control cancer, we collect cancer data of our whole population through the Hong Kong Cancer Registry under the HA. In addition, the Behavioural Factor Surveillance System of the DH also collects information on health-related behaviours of the Hong Kong adult population through telephone surveys every year. The information collected can provide evidence to support and evaluate health promotion and cancer prevention programmes.

Strengthening enforcement of the smoking ban

56. To safeguard public health and strengthen anti-smoking efforts, the Government proposed to increase tobacco duty by 50% in its 2009-10 Budget early this year and the proposal was approved by the Legislative Council. At present, tobacco duty constitutes about 60% of the retail price of tobacco products. Several weeks after the increase of tobacco duty, there was a sharp

increase by more than 15 times in the average daily number of people making calls to the DH's smoking cessation hotline in comparison with the average figure for the whole year of 2008. Since 1 July this year, the smoking ban also took effect in the six types of establishment (namely, bars, clubs, nightclubs, bathhouses, massage establishments and mahjong-tin kau premises) which were previously allowed to be temporarily exempted from imposition of a full smoking ban, so as to protect their customers and staff from the hazards of passive smoking. Besides, following the implementation of a fixed penalty system for smoking offences on 1 September, staff of the Leisure and Cultural Services Department, Food and Environmental Hygiene Department and Housing Department can issue fixed penalty notices for smoking offences which take place in statutory no-smoking areas in public venues under their management. The amount of fixed penalty is HK$1,500 for offenders of smoking offences. Total smoking ban was further extended to all covered public transport interchanges in the territory on the same day to reduce the adverse impact of passive smoking to passengers of public transport. Should the implementation of smoking ban at these public transport interchanges prove to be satisfactory, we plan to extend the smoking ban to open public transport facilities next year.

57. Between January 2007 and September 2009, the Tobacco Control Office (TCO) issued a total of 15,189 summonses to smoking offenders. Since the implementation of total smoking ban in the six types of establishments on 1 July 2009, the TCO has instituted prosecution by way of summons for 80 cases of smoking offences committed in these establishments. In the preceding one month, it received a total of 44 complaints about illegal smoking at covered public transport interchanges where smoking ban is in force and three fixed penalty notices were issued.

58. Regarding publicity and education, since the enactment of the new legislation providing for the enlarged smoking ban, the DH has stepped up its efforts in education and publicity to enhance the public's understanding of the new legislation. The DH has recently updated the Announcement of Public Interest (TV and Radio) on tobacco control policy, and provided health education information and organised talks for the public, with a view to raising public awareness of the hazards of smoking and passive smoking, and enlisting public support for building a smoke-free environment and compliance with the legislation. In addition, in collaboration with the NGOs, the DH has introduced a community-based smoking cessation programme since January this

year. The programme covers a comprehensive range of activities and services including smoking cessation service, education for the public, training for healthcare professionals and research projects. Under the programme, a smoking cessation hotline has been set up and four smoking cessation centres have been established in the territory to provide free smoking cessation service. The operation hours of the centres include evenings and weekends to improve accessibility for the users. Moreover, we will continue to promote smoking cessation through the Council of Smoking and Health and at the district level.

Promoting healthy eating habits in schools and food premises

59. With social and economic developments, many people tend to consume food with a high content of fat, salt and sugar. In the long run, consumption of an imbalanced diet will not only lead to obesity but also pose risks to health. To encourage children to develop healthy eating habits, the DH will continue the EatSmart@school.hk Campaign in all local primary schools to promote healthy eating among school children. In addition, the DH has introduced the EatSmart School Accreditation Scheme to encourage cooperation among family, school and community in an effort to reduce the risk of obesity and non-communicable diseases in children. At the community level, the DH will continue the EatSmart@restaurant.hk Campaign to encourage and assist restaurants to make available on their menus more dishes with fruit and vegetables and with less oil, salt and sugar. This will provide more healthy choices for the public. The DH will monitor the development of the Campaign and evaluate its effectiveness, and continue to promote the importance of healthy eating.

Developing a statutory regulatory proposal on medical devices

60. Currently, medical devices containing pharmaceutical products or emitting ionising radiation are already subject to statutory regulation. To further safeguard public health, we have put in place a Medical Device Administrative Control System since 2004. This System facilitates the monitoring of the use of medical devices by the Government and enables the trades to familiarise themselves with the listing requirements to pave the way for implementing a statutory control framework in future.

61. The regulatory impact assessment carried out by the consultant commissioned by the DH has been completed. The Government is now

developing a statutory regulatory proposal on medical devices. We will take into account the findings of the regulatory impact assessment, the views of the stakeholders and the public, and the experience gained from the operation of the Medical Device Administrative Control System, etc on the subject. The Legislative Council Panel on Health Services will be consulted in this regard.

Continuing to promote the Central Organ Donation Register

62. The Central Organ Donation Register (CODR), established and managed by the DH, came into operation in November 2008. The CODR provides another channel for prospective organ donors to voluntarily register their details apart from filling in organ donation cards. Through the highly secured computer system, authorised transplant coordinators of the HA are able to access information of organ donors who have just passed away and arrange for organ transplantation. This will benefit more patients on the waiting list for organ transplantation. As at 30 September 2009, over 40,000 members of the public have registered on the CODR. The Hong Kong Medical Association is also seeking consent of the existing registrants of its Organ Donation Register to transfer their data to the CODR. We will continue to step up the promotion of organ donation and the CODR jointly with the relevant organisations to enhance public awareness of the importance of organ donation, and nurture a social culture which embraces the notion of voluntary organ donation, so as to increase the likelihood of successful organ donation and benefit more patients on the waiting list for organ transplant.

Food and Health Bureau
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