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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 10 January 2020

Development of primary healthcare and district health centre

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 and district health centre ("DHC").

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] reviewed the service delivery model for the healthcare system and issued the discussion paper "Building a Healthy Tomorrow". It 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 these recommendations, one of the healthcare service reform proposal put forth by the Government in the First Stage Healthcare Reform Consultation Document entitled "Your Health Your Life" in March 2008 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 then 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 diseases or disabilities. The identified major strategies to improve

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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.

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. The Primary Care Office was established in September 2010 under the Department of Health ("DH") to, among others, develop primary care conceptual models and reference frameworks with emphasis on the prevention and management of common chronic diseases; set up a Primary Care Directory to promote family doctor concept; and establish the Community Health Centres ("CHCs")[5] to provide integrated and comprehensive primary care services for chronic diseases management as well as patient empowerment programme. Other 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 Colorectal Cancer Screening 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").

6. As announced in the Chief Executive's 2017 Policy Address in October 2017, the current-term Government is determined to step up efforts to promote individual and community involvement, enhance co-ordination among various medical and social sectors, and strengthen district-level primary healthcare services. The aim of these measures is to encourage the public to take precautionary measures against diseases, enhance their capability in self-care and home care, and reduce the demand for hospitalization. The setting up of DHCs is one of the initiatives in this regard. Chaired by the Secretary for Food and Health, the Steering Committee on Primary Healthcare Development was established in November 2017 for a term of three years to develop a blueprint for the sustainable development of primary healthcare services for Hong Kong.

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[5] The Tin Shui Wai (Tin Yip Road) CHC, North Lantau CHC and Kwun Tong CHC commenced services in February 2012, September 2013 and March 2015 respectively.

It 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 is underpinned by a Working Group on District Health Centre Pilot Project in Kwai Tsing District. The Primary Healthcare Office was established under FHB in March 2019 to oversee the development of primary healthcare services at the bureau level. The Primary Care Office of DH has been integrated with the Primary Healthcare Office since October 2019.

7. The first DHC in Kwai Tsing District has commenced operation in September 2019 under a three-year service contract which was awarded to a non-public operator with contract sum of $284 million through open tender.

Deliberations of the Panel

8. The Panel discussed issues relating to the development of primary care and the establishment of DHC in Kwai Tsing District at various meetings. Views from deputations on the DHC Pilot Project were received at the special meeting of the Panel on 26 March 2018. The deliberations and concerns of members are summarized in the following paragraphs.

Primary care conceptual models and clinical protocols

9. 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.

10. 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

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 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.

Service mode of CHCs

13. Question was raised about the mode of service of CHC. According to the Administration and HA, CHC 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. It should be noted that the co-location of different healthcare services 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

14. 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. Members were advised that having critically reviewed the strategic direction of EHCs, DH would implement a pilot collaborative model at EHCs with non-governmental organizations ("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.

15. 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. Members were pleased to note that the annual voucher amount was increased to $2,000 when the EHV Scheme was converted from a pilot project into a recurrent programme in 2014, the eligibility age was lowered from 70 to 65 years old in July 2017, and the financial cap on the cumulative amount of the vouchers in the account of the eligible elderly was increased to $8,000 in June 2019. Members were of further view that consideration should be given to allowing eligible elderly couples to share between themselves the amount of vouchers in their voucher accounts.

General outpatient services

16. Members noted that under the GOPC PPP Programme launched by HA in mid-2014 in Kwun Tong, Wong Tai Sin and Tuen Mun, 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. 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.

17. Members considered that HA should provide round-the-clock general outpatient services. Separately, given that many patients with episodic illnesses were unable to make an appointment for the next 24 hours through the GOPC telephone appointment system, some members suggested that HA should

extend the available appointment timeslots from within the next 24 hours to the next 48 hours. HA advised that to avoid patients delayed their medical consultation, those patients who could not make an appointment could try again through the GOPC telephone appointment system or seek timely intervention elsewhere if indicated including the private sector which currently provided over 70% of outpatient consultations.

Dental care services

18. There was a call for the Administration to pilot the provision of comprehensive dental care services for members of the public in a general hospital of each hospital cluster, with a view to facilitating the planning of further service enhancement in this regard. Members expressed concern that while the free emergency dental services at government dental clinics were far from adequate to meet the needs of the elders, the high service charges of the private dentists had deterred the elders from using EHVs to seek dental care in the private sector. 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.

19. According to the Administration, in addition to the provision of free emergency dental services at government dental clinics, specialist and emergency dental services were currently provided for patients with urgent or special oral healthcare needs in some public hospitals. A number of initiatives had been launched in recent years to enhance the dental care support for persons with special needs. These included the Elderly Dental Assistance 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, and the provision of free outreach dental care services to elderly in residential care homes or day care centres through outreach dental teams set up by NGOs. Members were of the view that the number of elders benefited from these 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.

Health assessment and cancer screening

20. 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 members of the public. Members were however advised in 2016 that the Elderly Health Assessment Pilot Programme launched in 2013 to provide subsidized health assessment service for up to 10 000 eligible elderly aged 70 or above[6] would not be further pursued as the programme appeared to be not attractive to the elderly and participating NGOs also faced various operational difficulties in recruitment of target elderly, employment of suitable healthcare professionals, and meeting the high administrative, laboratory and manpower costs. Some members did not subscribe to the view of the Administration. They considered that the initiative could help detecting previously unidentified health risks or problems of the participating elderly, including those hard-to-reach elderly.

21. Members noted that the Colorectal Cancer Screening Pilot Programme launched in September 2016 to provide subsidized colorectal cancer screening for higher risk groups was regularized in August 2018 to cover Hong Kong residents aged between 50 and 75 in phases. Some members were concerned that the initiative would widen the gap between those participants with a positive faecal immunochemical test ("FIT") 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 full subsidy subject to means test should be provided to the less privileged FIT positive participants.

22. 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. Members were advised that starting from the 2019-2020 school year, free human papillomaviruses vaccination would be introduced for Primary Five and Six

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[6] 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.

female students. For breast cancer, 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.

Pilot DHC in Kwai Tsing District

23. Noting that various primary healthcare services were currently being provided in the community by DH, HA and NGOs, members enquired about the role of the pilot DHC in this regard. They were particularly concerned about the difference between the operation mode of the proposed DHC 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 DHC 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 public-private partnership. The Pilot DHC would serve as a hub on the provision of co-ordinated primary healthcare services at multiple access points, with a core centre serving as its headquarters.

24. Some members were concerned about the governance structure, the manpower requirement and the public funding required to support the operation of the pilot DHC, as well as the levels of fee to be charged by the private service providers. The Administration advised that a mechanism would be put in place to provide guidance and oversight to the operator of the pilot DHC. In terms of manpower support, the operator of the pilot DHC would need to have a core team of staff. In addition, it had to make use of the local network to procure services from organizations and healthcare personnel serving the district to provide a range of co-ordinated care and support services at multiple access points to meet the specific health needs of the population of Kwai Tsing District.

25. Members considered that the pilot DHC should aim to meet the specific health needs of the population in Kwai Tsing District. They drew to the Administration's attention that the District had large number of ethnic minorities and new immigrants and a high poverty rate. Some members shared the deputations' views that the scope of services to be provided by the pilot DHC should include, among others, oral health care services, screening and management of osteoporosis, eye care services, as well as health risk assessment and physical check-ups for women and elders to facilitate early identification of the health risk factors. The Administration advised that taking into account the health profile, in particular the prevalence of selected chronic diseases and health risk behaviours, of the population in Kwai Tsing District, the pilot DHC would direct resources to the treatment of the most prevalent chronic diseases

that consumed substantial medical resources and explore how to manage their conditions through risk management and early intervention.

26. Referring to the Administration's stance that a comprehensive and co-ordinated primary healthcare system would enhance overall public health, reduce hospital re-admission and rectify the situation where accident and emergency ("A&E") service was regarded as the first point of contact in seeking medical consultation, some members were concerned about how the pilot DHC could achieve the above objectives as the health assessment it provided might result in an increase in demand for further examination and diagnosis, and whether these examination and diagnosis, if needed, would be provided by HA.

27. The Administration advised that the A&E Departments of public hospitals currently handled a number of semi-urgent and non-urgent cases, among which some were related to inappropriate chronic disease management. There was a need to establish a more systematic and coherent platform to incentivize the community to manage their own health, to promote awareness of the importance of primary healthcare services and to improve service accessibility. The pilot DHC would encourage residents to manage their health with the assistance of healthcare service providers in their localities. Clients of the pilot DHC with health risk factors identified might be referred to a DHC network doctor for further examination and diagnosis as needed. Those patients who were diagnosed by the DHC network doctors with chronic diseases would be offered service packages.

28. Members opined that the pilot DHC should adopt a case management approach to ensure that its clients, most of whom might be elders suffering from the designated chronic diseases or with health risk factors, could receive appropriate district-based primary healthcare services offered by the service providers in the DHC network. They raised a particular concern about whether the operator of the pilot DHC would be capable of taking up a central co-ordination role among the service providers and take a proactive approach in assisting the DHC clients.

29. The Administration advised that apart from the core centre and the five satellite centres, the service network of the pilot DHC would comprise a number of medical and healthcare practitioners practising either in the Kwai Tsing District, or in the three districts immediately adjoining Kwai Tsing (Tsuen Wan, Shatin and Sham Shui Po) that had contracted with the pilot DHC operator. It should be noted that the DHC network doctors would be required to make reference to the relevant reference frameworks of the Primary Care Office on diagnostic criteria and the guidelines to be developed on chronic disease management. The Administration could explore in the longer term whether

there was a need to assign to each DHC client a designated case manager to follow up their service needs.

Setting up of DHC Express

30. It was announced in the Chief Executive's 2019 Policy Address that in the 11 districts where full-fledged DHCs would yet to be set up within the current-term Government, smaller interim DHC Express would be established to provide key primary healthcare services, including health promotion, health assessment and chronic disease management. These DHC Express services would migrate as appropriate to the local DHC at a later stage.

31. At the briefing on the policy initiatives in respect of health matters featuring in the Chief Executive's 2019 Policy Address on 21 October 2019, members sought explanation on the reason for establishing smaller DHC Express instead of DHCs in the remaining 11 districts. The Administration advised that within the term of the current government, DHCs would be set up in six more districts, including Sham Shui Po, Wong Tai Sin, Yuen Long, Tsuen Wan, Tuen Mun and Southern districts. The setting up DHC Express would help delivering deliver district-based primary healthcare services pending the setup of full-fledged DHC and facilitating community medical-social support to the public through identification of healthcare and social resources and early engagement of the community service partners in the districts.

Relevant papers

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

Council Business Division 2
Legislative Council Secretariat
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Appendix

Relevant papers on the development of primary healthcare and district health centre

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)

Committee	Date of meeting	Paper
Panel on Health Services	16.11.2015 (Item VI)	Agenda Minutes
	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 Minutes
	12.2.2018 (Item IV & V)	Agenda Minutes CB(2)243/18-19(01)
	26.3.2018 (Item I)	Agenda Minutes
	16.7.2018 (Item II)	Agenda Minutes CB(2)63/18-19(01)
	15.10.2018 (Item III)	Agenda Minutes
	18.3.2019 (Item IV)	Agenda Minutes
	21.10.2019 (Item I)	Agenda

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