For discussion
on 10 February 2023

Legislative Council Panel on Health Services

Primary Healthcare Blueprint

Purpose

This paper briefs Members on the latest progress of the development of primary healthcare.

Latest Development on Primary Healthcare

2. In face of the pressure brought about by an ageing population and the increasing prevalence of chronic diseases, the Government released the Primary Healthcare Blueprint (the Blueprint) on 19 December 2022 which sets direction for a reform of our healthcare system, to strengthen primary healthcare services in Hong Kong. Through strategies including prevention-oriented, community-based, family-centric, early detection and intervention, our vision is to improve the overall health status of the population, provide accessible and coherent healthcare services, and establish a sustainable healthcare system.

The Healthcare Challenges in Hong Kong

3. Hong Kong has one of the most rapidly ageing of population in the world and the speed of ageing will peak in the upcoming decade. The average annual increase rate of the population aged 65 and over will be 4.0% from 2021 to 2030. The population aged 65 and over will increase from 1.5 million (20% of the total population) in 2021 to 2.52 million (31% of the total population) in 2039. The proportion of old-old (aged 80 and over) will also rapidly increase from 0.4 million (5%) in 2021 to 0.93 million (11.5%) in 2039.

4. Ageing is also associated with increasing health and social care needs and higher prevalence of chronic diseases. The percentage of people who had chronic health conditions was 31% (around 2.2 million) in 2020/21, among which 47% were aged 65 and over. The number of

Hospital Authority (HA) patients with chronic diseases[1] is projected to reach 3 million in the coming decade by 2039. More alarmingly, a substantial number of patients with chronic diseases – believed to be as many as a double of the diagnosed number – remain undiagnosed and unmanaged. Hypertension (HT) and diabetes mellitus (DM) are the highest in prevalence especially among the aged.

5. Ageing population and increasing chronic diseases prevalence is expected to exert a heavy toll on secondary/tertiary care especially the public hospitals. The utilisation rate of hospital service rises exponentially for people aged 65 and over. Despite only making up 18% of the population, they accounted around half of all patient days and accident and emergency admissions and over one-third of General Out-patient Clinic (GOPC) and Specialist Out-patient Clinic (SOPC) attendances in 2019. Among GOPC, Family Medicine Specialist Clinic and SOPC patients, around 60% have selected chronic diseases, of which 82% have DM/HT. Among DM/HT patients, one in three has developed complications in 2019, and their per capita service cost was two times higher than those without complications.

Primary Healthcare Blueprint

6. To achieve better population health and quality of life, we need to shift the centre of gravity of our healthcare system from treatment-oriented, institution-centric secondary/tertiary healthcare to prevention-oriented, family-centric primary healthcare. Through well-managed and co-ordinated primary healthcare services at community level, we envisage that chronic disease patients' medical and health needs will be properly taken care of at the community level. In turn, alongside longevity, their physical well-being and quality of lives will be enhanced, their morbidity will be compressed and their needs for hospital care will be reduced and deferred. The overall health status of the population shall thereby be improved.

7. Our vision is to improve the overall health status of the population, provide accessible and coherent healthcare services, and establish a sustainable healthcare system. Under the guidance of the

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[1] With one of the 25 common chronic diseases: HT, DM, hyperlipidemia, coronary heart disease, stroke, chronic obstructive pulmonary disease, chronic heart failure, chronic kidney disease (stage 3a to 5), glaucoma, osteoporosis (approximated by hip fracture), hepatitis B, depression, dementia, parkinsonism and cancers of the colorectal region, breast, lung, liver, prostate, cervix, corpus, ovary, nasopharynx, stomach and non-hodgkin lymphoma.

Steering Committee on Primary Healthcare Development, the Blueprint focuses its discussion on five major aspects. The relevant chapters and major recommendations are summarised below:

(1) Develop a Community-based Primary Healthcare System

8. We propose to further develop a district-based family-centric community health system based on the District Health Centre (DHC) model with an emphasis on horizontal integration and co-ordination of district-based primary healthcare services through service co-ordination, strategy purchasing, and medical-social collaboration, and vertical integration and interfacing with secondary and tertiary care services through protocol-driven care pathway for specified chronic diseases supported by well-trained primary care family doctors. Under this principle, DHCs will progressively strengthen their role as the co-ordinator of community primary healthcare services and case manager to support primary healthcare doctors on one hand, and their role as district healthcare services and resource hub that connect the public and private services provided by different sectors in the community on the other hand, thereby re-defining the relationship among public and private healthcare services; as well as primary healthcare and social service providers.

Consolidation of Public Primary Healthcare Services

9. Among a wide range of clinical services provided by Department of Health (DH), while most of them carry significant public health functions, some of them provide primary healthcare services. As the district-based, family-centric community health system evolves, the Government proposes to progressively and orderly migrate primary healthcare services under DH to the primary healthcare system, with a view to developing community healthcare system and facilitating provision of comprehensive primary healthcare services, reducing service duplication and utilising resources effectively.

10. To this end, we have started discussion with DH to prioritise the service consolidation of Elderly Health Centres and Woman Health Centres with a view to merging into DHCs progressively, or other private healthcare providers through strategic purchasing or public-private partnership (PPP) as appropriate. According to the same principle, DH's other primary healthcare services shall be gradually migrated under a phased approach, taking into account the level of synergy and impact of service transition.

Chronic Disease Care

11. Chronic diseases are a major public health concern, if individuals at high risk or patients are not equipped with health awareness nor control their conditions proactively, it will bring irreversible impact on their quality of life and productivity of the economy due to their gradually deteriorating health conditions. The situation worsen when the associated complications are not timely intervened. It also causes heavy burden to the public healthcare system in terms of service utilisation, service cost and long-term financial burden. In view of this, the Blueprint recommends to facilitate early identification of the warning signs of chronic diseases and timely intervention through the establishment of community health system, including "family doctor for all" regime and a multi-disciplinary PPP model, as well as enhancing self-management ability, improving healthy lifestyle planning, so as to reduce patients' reliance to the healthcare services. It also provides an additional choice of services for chronic disease patients outside the public healthcare system.

12. As announced in the 2022 Policy Address, the Government would introduce a three-year "Chronic Disease Co-Care Pilot Scheme" (CDCC Scheme) in Q3 2023 with a view to enhancing public awareness of chronic disease prevention and management, empowering citizens to identify health risk through screening. DHC will coordinate and promote the CDCC Scheme to support citizens to manage their own health; and conduct health planning for targeted citizens with high risk of HT or DM and provide further follow-ups, suggestions, examination as well as appropriate preventive and curative services in collaboration with community network, private service providers, including family doctors. In terms of subsidy, the Government will subsidise about half of the examination and treatment fees.

13. As a start, we recommend that the CDCC Scheme should first cover HT and DM patients in view of the high disease prevalence among chronic diseases. With CDCC Scheme, we anticipate to cultivate a long-term family doctor-patient relationship between the patient and his/her family doctor in order to achieve the objectives of family-centric continuous and holistic primary healthcare. To formulate clinical service protocol and standard of the relevant programme, Task Force on Chronic Disease Co-Care Scheme was established in December 2022 and has been conducting working meetings to deliberate on the implementation details.

14. CDCC Scheme aims to better utilise private primary healthcare resources. Based on a co-payment model, the CDCC Scheme allows citizens to manage their chronic diseases through the family doctor regime to be established and supported by relevant subsidy. In terms of the actual fee level, we will formulate the proposal and provide necessary incentives with reference to market price, operational model as well as citizens' affordability in order to achieve the intended healthcare goals and health system changes. Strategic Purchasing Office (SPO) will conduct research on the co-payment level of participating patients, corresponding level of Government subsidy to each citizen as well as the additional government expenditure bring about by the programme and announce the details in due course. In the meantime, under CDCC Scheme, we will set up a community drug formulary to reduce drug price by increasing purchasing power, so that patient in the programme can purchase the drugs required at a lower price. The SPO (see paragraphs 31 to 33 below) will be responsible for devising the purchasing model of CDCC Scheme.

Repositioning of Hospital Authority's General Out-patient Clinic

15. The current public healthcare system serves as an essential safety net for the population, especially those who lack the means to pay for their own healthcare. We need to maintain and improve the coverage and quality of healthcare services provided for those who cannot afford private healthcare services so that no one should be denied adequate healthcare due to lack of means.

16. With the introduction of the CDCC Scheme, we see the need to reposition GOPCs progressively to enable targeted use of public resources. To ensure that the public healthcare system would continue to serve as an essential safety net for the population, it is proposed that GOPC service should take priority care of the socially disadvantaged population groups (especially low-income families and the poor elderly)[2].

(2) Strengthen Primary Healthcare Governance

17. We acknowledge that the existing health governance structure has not placed enough emphasis on primary healthcare. The Blueprint recommends a holistic approach at the policy level in addressing the systemic imbalances between primary healthcare and secondary/tertiary

[2] In 2019/20, among GOPCs' HT/DM patients (excluding patients with civil servants/HA staff benefits), about 23% were fee-waiving patients (i.e. recipients of Comprehensive Social Security Assistance or Higher Old Age Living Allowance or other fee waivers).

healthcare in terms of policymaking, financing, manpower, regulation and outcome monitoring. In addition, the Blueprint also recommend to strengthen co-ordination to ensure the implementation of the commitment to drive institutional changes and enhance cross-sectoral and inter-organisational co-ordination among primary healthcare services in an integrated manner.

Primary Healthcare Commission

18. In the light of the above, we consider that an overarching governance structure focusing on positioning primary healthcare as a health system priority is essential to enable a vision- and mission- led policymaking process. We will progressively transform the Primary Healthcare Office currently under Health Bureau (HHB) into a Primary Healthcare Commission empowered to oversee primary healthcare service delivery, standard setting, quality assurance and training of primary healthcare professionals under one roof, as well as primary healthcare service planning and resource allocation through strategic purchasing supported by SPO. It should also be tasked to review the roles of different key service providers in primary healthcare and enhance cross-sectoral and inter-organisational co-ordination.

19. Upon the establishment of the Primary Healthcare Commission, DH will maintain its public health functions and continue to serve as the Government's public health adviser in planning the overall public health strategy over the territory and executing its regulatory and enforcement roles. In addition, it shall be tasked to monitor and facilitate the development of health technology and the research and development of drugs, so as to enhance its capability to cater for the future development of public health. On the other hand, HA is envisaged to focus on its provision of public hospital and related medical treatment and rehabilitation services to the public in accordance with the Hospital Authority Ordinance, whereas its primary healthcare services should only focus to serve as an essential safety net for the population, especially those who lack the means to pay, under the direction of the Primary Healthcare Commission.

Primary Care Register and Reference Frameworks in Primary Care Settings

20. We see the need for standardisation and assurance of the quality of primary healthcare services across public and private providers to ensure that the whole primary healthcare system is driving towards the

Government's overall primary healthcare policy and delivering the intended health outcomes. To this end, we propose transforming the existing Primary Care Directory (PCD) into a Primary Care Register (PCR) to serve as a central register for all primary healthcare professionals under one umbrella, and to introduce improvements to the existing Reference Frameworks (RFs) in primary care settings as levers for standardised primary healthcare and quality assurance tools.

21. The Primary Healthcare Commission will be tasked to oversee the management and improvements of the PCR and RFs. We propose to require all healthcare professionals participating in primary healthcare service provision to be enlisted on the PCR and commit to using the primary healthcare RFs, including those enrolling in government-subsidised programmes such as the Elderly Health Care Voucher (EHCV) Scheme and various primary healthcare PPP Programmes[3] including CDCC Scheme, in order to provide quality assurance to users of primary healthcare services, establish the service standard for primary healthcare service providers, and provide incentives for primary healthcare professionals to adopt best practices and participate in co-ordinated care. Through the above, continuous improvements in health service quality and performance with a view to safeguarding high standards of primary healthcare in supporting the Government's health initiatives are envisaged. New legislation would be required to provide the mandate and statutory powers for the Primary Healthcare Commission to implement the standards on private primary healthcare service providers.

Two-way Referral Mechanism between Primary and Secondary Healthcare

22. To address the problem of multiple points of contact in the current healthcare system, a clear patient pathway and primary-secondary referral protocol is required to gate-keep the access to the public secondary healthcare system and de-duplicate the functions of GOPCs and SOPCs. An evidence-based, two-way protocol-driven referral mechanism, in particular for the specified chronic diseases, should be established for both the public and private sector with the specialist and hospital services, to ensure only those warranted cases would be uploaded to the secondary level; whereas stable cases should be downloaded back to the primary level for ongoing care.

[3] Examples include the Colorectal Cancer Screening Programme, Government Vaccination Programme, GOPC PPP, etc.

23. We recommend to task HA to develop the referral mechanism based on the existing referral system in the public health system, starting with the specified chronic diseases (i.e. HT and DM). Upon establishing such a protocol-driven referral mechanism, we recommend to establish the primary-secondary referral mechanism between primary healthcare service providers in both the public and private sectors with the public hospital system, emphasising the effective discharge of case management and gatekeeping role of primary healthcare service providers, allowing timely and appropriate referral of patients with complications by primary healthcare doctors to public hospitals for secondary care, and downloading of stabilised patients by public hospitals to primary healthcare doctors for continuous monitoring and management.

24. Through effective gate-keeping and triage, we envisage that the improved primary healthcare system should be able to serve as the gate-keeper and case manager to the public secondary healthcare system with the aim of retaining most of the patients with stable condition at the primary level for continuous care, and helping patients navigate each level of the healthcare system efficiently and thereby addressing the need, demand and the waiting time for SOPCs.

(3) Consolidate Primary Healthcare Resources

25. The current health expenditure allocation is heavily skewed towards secondary and tertiary healthcare. In order to shift the focus of the current health system towards primary healthcare, we need to expand expenditure on primary healthcare services as an upfront investment so as to enable reallocation of healthcare resources from the secondary/tertiary to primary healthcare level and to attain better health outcome and a sustainable healthcare financing and delivery model. Apart from injecting new resources through increasing public expenditure, we need to explore reallocation from and better utilisation of existing resources.

26. We propose to make wider use of market capacity and adopt the "co-payment" principle to provide government subsidised primary healthcare programmes. This will incentivise citizens to use private healthcare services under government subsidised programmes. In addition, we propose to improve existing financing schemes to enhance the efficiency of resources and improve the quality of primary healthcare services in the community.

Elderly Health Care Voucher

27. The Government has implemented the EHCV Scheme since 2009. Currently, the EHCV Scheme subsidises eligible Hong Kong elderly persons aged 65 and over with an annual voucher amount of $2,000 (accumulation limit of $8,000). It adopts the concept of "money following the patient" which allows eligible individuals to choose private primary healthcare services that best suit their health needs. The Scheme aims to provide elderly persons with additional primary healthcare service options.

28. The EHCV Scheme utilises about 18% of the existing public primary healthcare resources annually (excluding COVID-related primary healthcare expenditure). According to the comprehensive review of the EHCV Scheme in early 2019, the utilisation of EHCV is skewed towards acute services rather than disease prevention or chronic disease management. Following the review, the Government progressively rolled out various measures to optimise the operation of the Scheme, including allowing the use of the vouchers at DHCs; strengthening education for the elders on the proper use of the vouchers and forward planning; enhancing the checking, auditing and monitoring of voucher claims; minimising over-concentration of voucher use, etc.

29. In order to achieve the health goals of primary healthcare as set out in the Blueprint, we propose to look into the optimisation of resources invested in the EHCV Scheme to ensure that it can effectively achieve the objective of promoting primary healthcare. As covered in the 2022 Policy Address, we will roll out a three-year pilot scheme to encourage the more effective use of primary healthcare services by the elderly, increasing the annual voucher from the existing $2,000 to $2,500. The additional $500 will be allotted to their account upon claiming at least $1,000 from the voucher for designated primary healthcare services[4]. The additional amount should also be used for those designated services. We are actively studying the implementation details of the proposed direction, as well as the views and suggestions of relevant stakeholders. Upon rationalising the implementation details, we aim to implement the relevant proposal in Q4 2023.

[4] The relevant amount of voucher are applicable to disease prevention and health management use, including appropriate health assessment, chronic diseases screening and management, for example (i) Western medicine practitioners: health assessment/ body check/ screening (screening for diabetes and hypertension), vaccination and prescription of preventive drugs, and treatment of chronic diseases, etc.; (ii) Chinese medicine practitioners: health assessment and chronic disease management, etc.; (iii) Dentists: dental examination, scaling, extraction and filing, etc.

30. Going forward, the voucher user would need to register with a family doctor (which is listed on the PCR), in order for the use of vouchers with the family doctor concerned to be treated as a designated use. The goal is to encourage elders to make good use of their vouchers to choose primary healthcare services for disease prevention and health management more effectively. We will continue to keep in view the operation of EHCV Scheme and make appropriate adjustments and take suitable measures as necessary so that elders could make proper use of vouchers for their own health by choosing appropriate primary healthcare services for disease prevention and health management.

Strategic Purchasing Office

31. 2022 Policy Address announced the establishment of SPO to co-ordinate primary healthcare services provided to the citizens through the private healthcare sector, with a view to complementing to the Blueprint in providing citizens comprehensive, sustainable and person-centric primary healthcare services in the community. We will adopt strategic purchasing as a tool to purchase primary healthcare services from private sector by subsidy and co-payment model under Hong Kong's existing dual-track healthcare system in order to provide additional healthcare service options to individuals and families so as to achieve the greatest health benefits and efficiency for the citizens.

32. Strategic purchasing defines which health services to be bought from whom, how these health services should be paid for, at what rate should be paid, and the payment and incentive mechanisms. We will provide incentives to healthcare service users and providers, encourage and induce citizens to adopt evidence-based healthcare service appropriately, so as to meet their healthcare needs and enhance health benefits.

33. The SPO will develop and roll out a common platform to facilitate integrated purchasing of healthcare services, including consolidation of existing HA and DH's PPP programmes, and formulate initiatives to meet health policy direction. SPO will conduct ongoing surveillance, monitoring and assessment of the relevant services with a view to ensuring efficient use of resources.

Land Resources for Primary Healthcare Services

34. Aside from financial resources, another important angle in developing primary healthcare is the availability of land resources. We recommend to pursue development and redevelopment of government buildings and premises for healthcare facilities in the community and to examine the feasibility of providing accommodation space for certain private healthcare service providers or non-government organisations to provide primary healthcare services, in order to facilitate their development as part and parcel of the district-based community health system, and the delivery of seamless, co-ordinated and continuous primary healthcare through co-location. We have set up the Steering Committee on Healthcare Facilities Planning and Development to coordinate the development of healthcare facilities and redevelopment of government healthcare facilities including those for primary healthcare services.

(4) Reinforce Primary Healthcare Manpower

35. The sustained delivery of quality and adequate primary healthcare services relies on a stable and sufficient supply of qualified primary healthcare manpower with the necessary knowledge, skills and attitude, who embrace the concept of multi-disciplinary teamwork in providing primary healthcare services in the community. The training and enhancing of the role of primary healthcare professionals is essential to ensure adequate and quality manpower supply.

Ensure Adequate Supply of Primary Healthcare Professionals

36. To ensure adequate supply of primary healthcare-related professionals, the Government will review the manpower projection model and formulate strategies to more systematically project the demand for primary healthcare professionals taking into account healthcare demands of the population as a whole, the recommendations in the Blueprint, and provision of primary healthcare services in both the public and private sectors, and with a view to ensuring a sufficient supply of primary healthcare professionals through provision of subsidised local training places as well as attraction of non-locally trained professionals.

Enhance Primary Healthcare Training for Healthcare Professionals and Promotion of a Multi-disciplinary Approach

37. We will also enhance primary healthcare-related training for all primary healthcare service providers and to set training requirements under

PCR, so as to facilitate healthcare professionals in both the public and private sectors to play a more active role in the development of primary healthcare under a team approach and operate in a co-ordinated fashion as part and parcel of the district-based community health system.

38. On the other hand, we shall progressively enhance the role of Chinese medicine practitioners, community pharmacists as well as other primary healthcare professionals in the delivery of primary healthcare services, through undergraduate and postgraduate education, and clinical practice in primary healthcare. Through professional-driven and evidence-based care models and protocols under the aegis of the Primary Healthcare Commission with the necessary resource allocation and referral pathways, they will be part of the co-ordinated and coherent primary healthcare system at the community level.

Enhance the Role of Chinese Medicine Practitioners and Chinese Medicine in the Primary Healthcare Services

39. Chinese Medicine (CM) constitutes an integral part of Hong Kong's healthcare system, the 18 Chinese Medicine Clinics cum Training and Research Centres of the HA over the territory and private Chinese medicine practitioners have been providing CM services to the public at the primary healthcare level. To give full play on the strengths and advantages of CM, the Government will continue to strengthen the role of CM in primary healthcare services, enhance multi-disciplinary collaboration, and explore possible model for further synergies with CM in primary healthcare settings at areas including promotion and education, health assessment, disease prevention, etc. Among others, chronic disease prevention and health management is one of the key focuses. In addition, the Government will facilitate relevant training programmes to foster mutual understanding among the different healthcare professionals who provide primary healthcare services.

Enhance the Role of Allied Health Professionals and Community Pharmacists in the Primary Healthcare Workforce

40. The Government sees the need to strengthen the role of other healthcare professionals in the local healthcare system, especially in primary healthcare settings. We recommend to look into the regulatory restrictions on allied health professionals to enhance their functions and roles in the primary healthcare workforce with a view to broadening the coverage of primary healthcare services and enabling more professionals to assume primary healthcare responsibilities.

41. In particular, we recommend to follow up with the statutory Boards and Councils of various healthcare professions on the recommendations in the Report of the Strategic Review on Healthcare Manpower Planning and Professional Development promulgated in 2017, including proposing legislative amendments to allow patients to have direct access to healthcare professional services (e.g. physiotherapy and occupational therapy) under specific circumstances, without a doctor's referral.

42. Furthermore, to ensure the professional competency of healthcare personnel, we will legislate to make continuing professional education and/or Continuing Professional Development a mandatory requirement for supplementary medical professionals under the Supplementary Medical Professions Ordinance, as well as nurses and dentists. Drawing on the experience in implementing the on-going voluntary Accredited Registers Scheme for Healthcare Professions, we will also explore the feasibility of introducing a statutory registration regime for those healthcare professionals who are currently not subject to statutory registration requirements such as clinical psychologists, speech therapists and dietitians, with a view to protecting public interest.

(5) Improve Data Connectivity and Health Surveillance

43. Comprehensive and efficient connectivity of the digital healthcare data network allow healthcare service providers in the public and private sectors to access and share patients' health records immediately which is essential to facilitate and co-ordinate the delivery of continuous healthcare for individuals and the collection of essential and accurate health surveillance data for effective healthcare policy and services planning for the population as a whole. We propose to transform the Electronic Health Record Sharing System (eHealth) from a basic health record sharing system into a comprehensive and integrated underpinning information infrastructure for healthcare data sharing, service delivery and process management especially primary healthcare-related services with multiple function layers to facilitate service record keeping, essential data sharing (such as allergies, diagnoses, prescriptions, etc.), health monitoring and surveillance, case and workflow management (including triage, referral and payment), and explore the use of big data analytics to contribute to population health surveillance and individual health management.

44. In order to enable eHealth to better play its function of data connection, we will require healthcare providers and the public in all subsidised government healthcare programmes to participate and use eHealth mandatorily, with a view to underpinning the gate-keeping and referral mechanism proposed in the Blueprint and enhancing care co-ordination and health surveillance. We target to develop eHealth into the healthcare database of Hong Kong gradually. In the longer run, we recommend to require all primary healthcare service providers to use eHealth and input the essential medical data, health and service data of healthcare service users into the eHealth account of the relevant users, with a view to strengthening protection for users, monitoring service quality and raising healthcare standards, and enhancing co-ordination and continuity of the healthcare process especially primary healthcare at the community level and referral to and from the public hospital system, through mandates by projected necessary amendments to the Electronic Health Record Sharing System Ordinance (Cap. 625) and inclusion of relevant requirements in PCR and PPP programmes.

45. Aside from boosting the impact of the eHealth, we also see the need to strengthen health surveillance and analyse health-related data, including population health status, health-related lifestyles, other health parameters and socio-demographic data, etc., to facilitate the Government in population health management through analysing the big data in order to devise healthcare policies and strategies in a precise and an evidence-based manner. To achieve the above, we propose to transform the existing Research Office into a dedicated Research and Data Analytics Office under HHB to develop a population-based health dataset and conduct on-going data analytics and surveys, and commission research studies on population-based health status, disease pattern and burden, and health seeking behaviour, with a view to providing the necessary data, evidence and analysis to support health policy making by the Government, primary healthcare service planning and resource allocation by the Primary Healthcare Commission, as well as the corresponding service planning and resource allocation for the public hospital system. The Office should also more effectively promote big data applications and monitor the progress and evaluate the impact of public health interventions to provide ongoing guidance on public health policy and strategies.

Implementation of the Blueprint

46. Since the launch of the Blueprint, HHB has been actively introducing the Blueprint to the society and various stakeholders (including

medical sector, social and welfare sector, think tanks, academia, patient groups, etc.) and solicit views on the recommendations in the Blueprint. Meanwhile, a series of publicity and educational activities have been rolled out, including publicity videos, thematic website, media interviews and feature articles, aiming to promote the concept of primary healthcare and the importance of chronic disease prevention to the public.

47. To signify our commitment to take forward the important initiatives in the Blueprint, the Government has organised the Primary Healthcare Blueprint Symposium on 15 January 2023 with nearly 300 guests from diverse backgrounds attended, including members of the Executive Council and the Legislative Council, as well as representatives of healthcare professional bodies, academia, government departments, non-governmental organisations (NGOs) and patient groups, to have high-level discussion on the path forward for primary healthcare in Hong Kong. Apart from the guests attending in person, over 200 medical professionals who are listed in the PCD also attended the Symposium via video-conferencing as part of their continuing medical education. The Symposium focused on the key recommendations in the Blueprint and conducted in-depth discussion on areas including references of international case study, establishing local community healthcare system, establishing mechanism on family doctor concept and disease management, planning on primary healthcare manpower training, strategic purchasing approach and achieving health surveillance and medical-social collaboration model through data connectivity. Through the inspiring discussions during the Symposium, they could keep abreast of the latest development of and vision for primary healthcare.

48. In addition, the Government has also organised the Primary Healthcare Blueprint Forum on 19 January to introduce the Blueprint to nearly 40 participants from NGOs and patients group. Representatives from social and welfare sector, and patients group conducted discussion on service network and medical-social collaboration, shared their insights on optimising and enhancing cross-sectoral collaboration and exchanged views on enhancing engagement of local communities, and co-developing chronic diseases prevention and curative services in the community. Community organisations expressed their supports on the development of primary healthcare which will empower individuals in self-management of health as well as controlling their health data and records.

49. In accordance with the Blueprint recommendations, we shall proceed to commence discussion under the following working groups of

the Steering Committee on Primary Healthcare Development –

(a) Working Group on Primary Healthcare Landscape and Community Engagement
(b) Working Group on District Health Ecosystem and Financing Model
(c) Working Group on Monitoring and Governance
(d) Working Group on Manpower, Training and Health Surveillance

50. We expect to initiate some of the implemented plans in phases over the short, medium and long term. During the process, we will make reference to international literature and experiences on health system performance measurement in developing the assessment framework and performance indicators for the strategic purchasing, policy making, performance management and improvement of primary healthcare services of Hong Kong.

51. The successful development of primary healthcare services should bring about positive impacts to the healthcare system of Hong Kong at the system, organisation and individual levels. The Research and Data Analytics Office shall develop tools and indicators to measure the outcome in various areas in the Blueprint in order to continue to monitor and evaluate the success of various primary healthcare proposals.

Advice Sought

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

Health Bureau
Department of Health
Hospital Authority
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