Improving Hong Kong Health Care System
: The Pharmacist Perspective

by Ms Scarlett Pong,
President, The Practising Pharmacists Association of Hong Kong

Background

The Department of Health (DOH) and Hospital Authority (HA) are both to be honoured for their role in the healthcare of Hong Kong. It is through their supervisory role that the survival rate at birth and life expectancy has largely increased.[1] But as the Hong Kong population grows older, we will have more chronic illnesses to deal with, and these will inevitably cause increases in health spending. Our key concern is how we can reform our healthcare system so that it can achieve sustainability and equity and then to decide what is the best way to go about it?

The Harvard report identified five options in response to the escalating cost of healthcare and in reality these options are mainly financial options. With more expensive drugs and surgical operations being developed, the demand for more health care spending is unlikely to reduce as the number of our aging population increases. These options are not the real answer to the spiral of increasing healthcare spending, as they do not provide any mechanism to prevent wastage, abuse, mismanagement or fraud within our healthcare system. Nor do these options resolve the quality of care problem[2] described in the Harvard Report. We need more fundamental changes in the structure of our health care delivery system and health policies.

The major criticisms of our health care system are: focusing on the hospital-based tertiary care rather than the more cost-effective community-based primary care; lack of integration within the health care system; exclusion of Traditional Chinese Medicine (TCM) practitioners from the organized medical services; focusing on medical practice rather than the modern concept of multidisciplinary health care delivery model; and lack of effective regulating and external checking and balancing system for physicians. These are all areas

[1] Life expectancy at birth was 76 years for men and 82 years for women in 1997: Hong Kong a New Era

[2] The Harvard Report Section 4.2.1 Highly Variable Quality Of Care Page 52-73

demanding improvements and fundamental changes, which would lead our way to higher quality of care, patient safety, and more effective utilization of public resources.

Major Areas of Reform from the Pharmacist Perspective

We can identify from the Harvard report several aspects[3] in which significant improvements can be made, namely: -

(i) highly compartmentalized health care system and underdeveloped primary, preventive care and TCM;
(ii) inappropriate drug dispensing practices by physicians;
(iii) lack of external check and balance mechanism for prescribing practices in private sector; and
(iv) lack of freedom of choice in dispensing services.

We will examine each of these areas in details in the sections below:-

(a) Pharmacists as primary health care providers
(b) Separation of dispensing practice from prescribing practice
(c) Pharmacists as TCM herbal experts

Pharmacists as Primary Health Care Providers

As mentioned in the report, most public resources are invested in hospital services and the current health sector is oriented towards curative services. Primary health care, community medicine and disease prevention are underdeveloped. Traditional Chinese medicine is excluded from the organized medical system. Besides, the current health care system lacks integration, which adversely affects patients' health, confuses the patients and causes unnecessary expenditures for health services. Due to the inappropriate targeting and allocation of public resources, together with the compartmentalized system, the financial sustainability of Hong Kong's health care system is highly threatened. In light of limited public resources, many developed countries have already engaged in a transition to shift public resources towards the more cost-effective prevention, primary and outpatient

[3] The Harvard Report Section 4.1.3 Cost Effectiveness Page 51 Line 2

care, and develop integrated health care systems[4].

We share the same view with the report that with only limited resources in our society, our objective would be to better allocate our resources and provide quality health care in the most cost-effective manner. We strongly support the recommendations in the report that we should

- expand primary care and community medicine;
- fund more rehabilitative services;
- adopt the family doctor system;
- promote disease prevention and health promotion;
- promote better informed patients;
- integrate traditional Chinese medicine in the medicine in the medical system; and
- integrate disease prevention, primary, outpatient hospital, and rehabilitative care to provide "total care" to the public.

By definition, primary health care refers to

"The provision of first contact and continuing care in the community to all patients....it is characterized by ease of access to services and provision by generalist health professionals. It includes general medical, dental, pharmacy, nursing and a range of other community services, as well as their relations with informal (family and community) care, hospitals and social care."[5]

Hong Kong should develop and expand primary health care, and at the same time the Government should strengthen the roles of the primary health care providers, including family doctors, nurses, pharmacists, dentists etc.

Many developed countries have recognized the cost savings made by developing primary health care and strengthening the functions of primary health care providers. In UK, the NHS white papers on primary care recommend closer collaboration between general practitioners, community pharmacists, optometrists, dentists and other primary care professionals.

[4] The Harvard Report, pg. 6-8, 75-76

[5] The public's use of community pharmacies as a primary health care resource. The Pharmaceutical Journal, Vol 262

With regards to pharmacists, the models of pharmaceutical input to primary care prescribing were described in the white papers, including[7]:

- Review of repeat prescriptions (general practice based, pharmacy based, and in residential and nursing homes)
- Total medication review
- Development, monitoring, and updating of practice formularies
- Development of prescribing policies (for example, for antibiotics)
- Prescribing audit by disease or condition

One important aim of the white papers is to break down barriers, encouraging more inter-professional cooperation to provide services and greater mixing of skills. In Derbyshire, for example, community pharmacists were paired with general practitioners to review individual notes of 722 patients to identify any prescribing problems and 2960 (48%) were identified out of 6131 medicines reviewed[8]. The improved quality of care and cost savings through the intervention of community pharmacists is further witnessed in many other studies. One project in UK, for example, in which all clinical interventions made by the pharmacist over a 12-month period had been recorded and assessed, suggested that approximately 15 hospital admissions per community pharmacists per year could be prevented[9]. These can be translated into significant reduction in health expenditures and better well being of patients.

Every year, the Government invests a lot of resources in the education of the allied health care team, such as nurses and pharmacists. However, many of these allied health care practitioners are underutilized. Better utilization of these allied health care teams will certainly promote a higher quality of care to patients and achieve cost savings.

Pharmacists are experts in drugs. They received intense and exclusive education on the use of medicines. Being one of the primary health care providers, pharmacists can contributes to quality health care and cost savings in many ways such as to:

---

[7] Bradley C. Taylor R. Blenkinsopp A. Primary care opportunities and threats: developing prescribing in primary care. British Medical Journal 1997;314;744 (8 March)

[8] Hulme H. Wilson J. Burrill, Goldstein R. Rationalizing repeat prescribing: general practitioners and community pharmacists working together Pharm J 1996;257;R7

[9] Community pharmacists could prevent 150,000 hospital admissions. Pharmaceutical Journal, Vol 261 (Oct 1998)

1. Provide patient-oriented services, including maintenance of medication and drug allergy profiles, patient counselling, and self-care consultation services (non-prescription drug counselling, health care aids)[10].
2. Evaluate and monitor patients' drug therapy record and review prescription orders to ensure that a prescribed therapy is safe and rational; identify, solve or prevent actual or potential drug-related problems, e.g. possible contraindications, drug interactions or therapeutic duplication, allergic reactions and patients' non-compliance to drug treatment which may lead to hospitalization and unnecessary health expenditures
3. Provide public education and health promotion e.g. smoking cessation and advises on nutrition and diet.
4. Reduce the over-stretched emergency rooms[11] workload and manage minor ailments promptly. Pharmacists are ideally positioned in the community to advise patients on the selection and use of non-prescription drugs and the management of minor symptoms or ailments, refer patients to a physician when necessary. The absence of an appointment system, couple with ease of access, pharmacies should be developed as a first port of call for patients.
5. Advise physicians and other health care professionals on drug choices, taking into considerations the needs and conditions of individual patients, the efficacy and cost-effectiveness of different choices. Provide drug information and consultation services to other health care professionals.

Separation of Dispensing Practice from Prescribing Practice

One of the biggest flaws of our present healthcare system is that medical practitioners, with the exception of Government doctors and HA doctors, are predominantly dispensing doctors. They are practising the work of two professions, namely medicine and pharmacy. Doctor are expected to deliver professional pharmaceutical service as an integral part of their service, however, with rare exceptions, the dispensing service in private clinics is provided by untrained personnel with minimal supervision. There is no monitor for possible prescription errors, drug interactions or simply an overdose. There is inadequate counselling on the side effects of the prescription drugs, and the labelling of medications

[10] Pharmacists in Primary Health Care Reform. Pharmacy Connection Mar/Apr 1998

[11] In 1997, the accident and emergency departments of major public hospitals had 2,117,000 attendants - or 5,800 per day, (many of these may not be urgent cases): Hong Kong a New Era

often fails to fully communicate the type, dosage and instruction for use to the patients. All these factors compromise the quality of care and reduce patient satisfaction.

Clearly, there is a conflict of interest for doctors to sell the prescription drugs that they prescribed. A great temptation exists for physicians to increase revenue through excessive sales of drugs to patients. In a recent survey in the Next magazine,[12] patient's drug fees were shown to range from 25% to 60% of the overall charge for a patients' visit; with three to (an unbelievable) eleven items of drugs prescribed for common cold and allergic rhinitis. Doctors were making tremendous profit where the patents' drug fees were shown to be 2 to 7 times of the actual drug cost. These findings coincide with the Harvard consultation report: -

1. Physicians at private practice prescribe too many items[13]; antibiotic are prescribed too often but for too short a duration, little information is given to patients regarding the type of side effects of the drug
2 Physician earnings and fees are significantly higher than other professions in Hong Kong[14]

Most patients do not have enough information to make the best choice on drug or to evaluate a drug therapy. Drugs are dispensed by the physician where there is no external checking mechanism or competition for dispensing services. The result of this is a closed market and market economics do not apply[15]. Separation of dispensing practice from prescribing practice will allow the consumer to shop around and make significant savings on drug expenditure in the private sector.
Separation of dispensing practice from prescribing practice will eliminate physicians'

Currently, the dispensing service provided by untrained or unqualified dispensers in private

---

[12] "New Magazine", 4th June 1999, Page 68

[13] The Harvard Report Table 4.21 Prescribing behaviour Page 62.

	% receiving antibiotics	% prescribing full course of antibiotics (5 days)	% given more than 3 drugs	% explain usage of drug	% explain side effect of drugs
Private GP	68-90%	8%	62%	48.3%	25.9%
Public	59-71%	57.9%	30%	42.9%	21.4%

Such prescribing behaviour in the private sector give rise to increases in drug fees and encourage unnecessary follow-up visit.

[19] The Harvard Report Page 51 "Relative to the median employment earnings of other professional in Hong Kong in 1997, private physicians earn at least 7 times over the earning of other professionals"

[20] The same should be noted for higher fees for procedures (operations) in Hong Kong private sector, even after adjusting for cost of living differences. These facts imply that patients may be paying more than what they have to pay under an effective competitive market.

sector and government clinics is a potential hazard to the general public[1617]. Separation of dispensing practice from prescribing practice allows pharmacists intervention in the dispensing process, providing a vital safety net against prescription errors and drug-related problems. Having the prescription passing through two different qualified and properly trained health professionals also significantly reduces undesirable medical incidents. Whilst there is no available data from the private sector, HA data show that there were over 6000 medication incidents voluntarily reported in HA hospitals in each of the 3 month period of the 1st and 2nd quarter of 1998.[18] Such findings may be extrapolated to the private sector and postulate that similar high incidences of prescription errors do happen in private practice as well. Obviously, the current practices of dispensing by untrained dispensers in private clinics place the general public in high risks and makes the need for the mandatory separation of the prescribing and dispensing even more compelling.

One may argue that patients can always ask their doctors for a prescription so that they can collect their medicine elsewhere. But in reality, patients rarely do so because doctors are regarded as authorities and a perception of difference in the social status between patients and doctors exists. If Hong Kong operates a separate prescribing and dispensing system, then patients' freedom of choice would be upheld and exploitation of the patient-physician relationship would cease to occur. Therefore, our association appointed The Chinese University of HK to do the study for us to understand this issue better.

The Harvard report found that there is little effort made to educate patients about drugs, especially in the private sector. It recommended the creation of an Office for Patient Education to provide patients with adequate knowledge and information to judge the quality of care provided and to articulate their concerns and dissatisfactions. We strongly believed that pharmacy can provide an informal and relax point of first contact for the patient and act as a source of unbiased information about their conditions and medications. Patient education is currently a neglected area that requires technical support and much greater advocacy.

It comes as no surprise that in a recent survey conducted by the Democratic Alliance for Betterment of Hong Kong, where 536 people were interviewed and over 60% of those

---

21 The adulteration of mouthwash in anti-pyretic mixture: Cheung Sha Wan Maternity Clinic, Apple Daily 4th December 19970

22 The undiluted chloroform in cough mixture: Kowloon Hospital, Apple Daily 13th March 1998

[23] Hospital Authority Medication Incidents Reporting Programme Bulletin No. 10

interviewed favour separation of prescribing and dispensing[16]. It is clear that dispensing is the domain of the pharmacist as diagnosis is the perrogative of the doctor, thus serious consideration should be given to the quotation from Lloyd George"....the person who signed the death certificate should not supply the medicine."

Trained Professionals as TCM Pharmacists

The Preparatory Committee on Chinese Medicine was set up in April 1995 to advise on a statutory framework for the promotion, development and regulations of traditional Chinese medicines in Hong Kong. The committee finalized its recommendations on the regulation and development of TCM and submitted its report to the government in March 1997. A Chinese Medicine Bill was introduced into the Legislative Council on 3rd February 1999, to make provisions for the registration of practitioner in Chinese medicine, the licensing of traders in Chinese medicine and the registration of proprietary Chinese medicine.

Annex B of the Chinese Medicine Bill contains the licensing and control mechanism for Chinese medicine. It includes licensing of retailers and wholesalers of Chinese herbal medicine, licensing of wholesalers and manufacturers of proprietary Chinese medicine, and the registration of individual proprietary Chinese medicine.

The more potent (toxic) prescription only herbal medicine are classified in Schedule 1 and Schedule 2 contains the more commonly used herbal medicine. There is no qualification requirement for TCM pharmacists and/or dispensers. Any businessman can apply for a retailer license, provided that he can appoint an "experienced and capable person" to supervise the daily running of a herbal retail shop. It does not define what level of proficiency an "experienced / capable" person must possess. As there are no organized training for TCM dispenser, anyone with minimal on-job experience may be qualified in running the dispensary operations. In sharp contrast, TCM pharmacists in China and the province of Taiwan are properly trained and qualified Only TCM pharmacists of such caliber are capable to advise on dosage, contra-indications, precautions, and drug interactions, delivering a high quality of care to the patients. The Practising Pharmacists Association of Hong Kong believe that a proper framework for TCM pharmacists must be set up to ensure an optimum standard of practice be attained. These must include a system of examination, registration, and discipline for TCM pharmacists. Only registered TCM pharmacists should be allowed to supervise the daily running of a herbal retail shop.

[16] Apple Daily 16th January 1999

Recommendations:-

(1) **Separation of Prescribing and Dispensing**

Steps Forward in the Separation of Dispensing Practice from Prescribing Practice

We understand that the separation cannot happen overnight and a carefully planned schedule is necessary for the preparation work and for the public to adapt to the new system. We recommend developing a five years schedule for stepwise implementation of the separation. The timetable will include the necessary amendments in legislation, imposing continuing education programs for pharmacists, upgrading and standardizing community pharmacy management, supplying more qualified pharmacists in university, and promoting the new system to the public.

Before the separation is fully implemented, we recommend some interim measures to be taken meanwhile: -

(a) Mandatory Prescription Writing

Prescription must be written to every patient[17] by all doctors. It must be handed directly to patients. It will offer the patient an opportunity to learn more about their medications and, most importantly, the patient can choose to dispense their drugs at their consulting clinic or at any other clinics or community pharmacies. In a recent CUHK survey on mandatory prescription writing, 608 people were interviewed and 67% of those interviewed, agreed with the idea of mandatory prescription writing. 78.8% of those interviewed, agreed that doctors should have the consultation and drug fee separately listed. (Details of the study are attached)

(b) Mandatory Prescription Drug Labeling

[17] Except for hospitalized patients or in an emergency situation.

The Harvard report found in one of their studies that a significant number (25%) of drug labels were not interpretable even to medically trained researchers.[18] Labels are intended to impart information and improve patient care. Labels can only achieve these objectives if they clearly print the generic names, and provide sufficient information about dosage, route of administration and precautions. The present labeling guidelines are not effectively implemented, but it can be achieved if the labeling requirements are standardized and laid down in law.

(c) Pharmacists run Government Clinics

At present, none of the 88 government clinics operate under the pharmacist' personal supervision. Whilst the government intend to employ a handful of pharmacists to supervise the dispensing activities at some of the busiest clinics, many of these clinics will continue to dispense medicines in the absence of a pharmacist. The government should follow the example set forth by HA and be a model for our healthcare system. It must decide immediately if it wants to staff all clinics with pharmacists or let doctors issue prescriptions to be dispensed in community pharmacies. It should not wait and allow the hazardous dispensing activity to continue.

(2) **More Deregulation of POM to P**

An effective use of pharmacists' as health resources would be the promotion of self-medication for minor ailments and the deregulation of the more prescription only medicines (POM) to pharmacy only medicine (P). Self-medication will allow the patient to take a bigger interest in his or her own healthcare. Take smoke cessation therapy as an example, it is absurd that a patient need a prescription to obtain his nicotine replacement gums/patches, but he can buy his cigarettes from any grocery or supermarket easily. Pharmacist need a board array of effective pharmacy only medicines to carry out their work effectively.

(3) **Framework for TCM Pharmacist**

[18] Harvard report p.g. 65

The Practising Pharmacist Association of Hong Kong believe that only qualified TCM pharmacists should be allowed to supervise the daily running of a retail herbal shop. A candidate must satisfactorily complete an undergraduate degree course in TCM herbal medicine or possesses with suitable healthcare academic qualification and take further training in traditional Chinese medicine. Only after passing a qualifying examination in TCM and spending a certain amount of time in internship should a candidate be allowed to register as TCM pharmacist. A TCM pharmacy Board should be set up to regulate its own members, and ensure a high standard of care is practised. It should promote professional development and full integration in the primary healthcare team.

Conclusion

In the search of an ideal strategy, our recommendations are built on one common thread, improve quality while containing costs. Pharmacists will demonstrate its added value to our health care system as the pharmacy profession redefines its role and contributions. The ultimate challenge for the government lies not just at shifting the financial burden, but the reformation and reorganization of our healthcare service.

香港中文大學香港亞太研究所

電話調查研究計劃

市民對醫藥分家的意見

電話訪問調查初步報告

(TEL/07/02/99/Ref.195)

一九九九年七月二日

此調查由香港執業藥劑師協會

抽樣方法及調查概況

是次電話調查由香港執業民意測驗協會，香港中文大學香港亞太研究所電話調查研究計劃負責籌劃及進行。此調查的抽樣方法如下：首先，從最新的香港住宅電話簿（英文版）中隨機抽出若干電話號碼；為了使未刊載之住宅電話號碼也有機會被選中，將已抽選的電話號碼最後的兩個數字刪去，再配上由電腦產生的隨機數字，成為是次調查的樣本。第二步，當成功接觸住戶後，再抽取其中一名十八歲或以上的家庭成員作為訪問對象。調查於一九九九年七月二日晚上六時至十時進行。抽樣結果如下：

抽選電話數目		3,000
線路有問題／線路經常繁忙	355	
非住宅電話	114	
無人接聽（經3次於不同時間嘗試）	757	
未用電話	392	
成功接觸住戶數目		1,382
拒絕受訪	433	
沒有合適被訪者／外籍人士	101	
其他問題（如電話錄音、傳真機等）	240	
成功訪問		608

成功接觸住戶後的訪問成功率

$$\frac{\text{成功訪問樣本}}{(\text{成功訪問} + \text{拒絕受訪})}$$

$= 608 \div (608 + 433) = 58.4\%$

* 這裡的結果以最後一次致電住戶時之回應為準。

調查結果（頻數及百分比分佈）

(1)「你贊唔贊成西醫應該將診金同藥費分開列明呢？」

	頻數	百分比	有效百分比	累積百分比
唔贊成	60	9.9	9.9	9.9
普通／一半半	31	5.1	5.1	15.0
贊成	479	78.8	78.8	93.8
唔知道／好難講	38	6.3	6.3	100.0
總計	608	100.0	100.0	

有效樣本 608 缺值樣本 0

(2)「你贊唔贊成西醫喺診症後即時主動向病人提供藥方，由病人自己選擇喺醫生診所或其他私人藥房配藥呢？」

	頻數	百分比	有效百分比	累積百分比
唔贊成	116	19.1	19.1	19.1
普通／一半半	54	8.9	8.9	28.0
贊成	408	67.1	67.1	95.1
唔知道／好難講	30	4.9	4.9	100.0
總計	608	100.0	100.0	

有效樣本 608 缺值樣本 0

(3)「你覺得現時大部份西醫要病人主動提出後，先會考慮開出藥方俾病人喺診所外配藥，咁樣係唔係剝削咗病人配藥嘅選擇權呢？」

	頻數	百分比	有效百分比	累積百分比
唔係	148	24.3	24.3	24.3
普通／一半半	58	9.5	9.5	33.9
係	345	56.7	56.7	90.6
唔知道／好難講	57	9.4	9.4	100.0
總計	608	100.0	100.0	

有效樣本 608 缺值樣本 0

(4)「你覺得現時本港若果實施彈性『醫藥一家，分工合作』嘅制度，即病人有權選擇喺醫生診所內配藥，或自行到街外藥房配藥，咁樣係唔係更能保障病人嘅權益呢？」

	頻數	百分比	有效百分比	累積百分比
唔係	57	9.4	9.4	9.4
普通／一半半	51	8.4	8.4	17.8
係	458	75.3	75.3	93.1
唔知道／好難講	42	6.9	6.9	100.0
總計	608	100.0	100.0	

有效樣本 608 缺值樣本 0

AGE 被訪者年齡

	頻數	百分比	有效百分比	累積百分比
18歲 - 20歲	47	7.7	7.8	7.8
21歲 - 30歲	128	21.1	21.2	29.0
31歲 - 40歲	184	30.3	30.5	59.5
41歲 - 50歲	128	21.1	21.2	80.8
51歲 - 60歲	42	6.9	7.0	87.7
61歲或以上	74	12.2	12.3	100.0
拒絕回答	5	0.8	缺值	
總計	608	100.0	100.0	

有效樣本 603 缺值樣本 5

EDU 被訪者教育程度

	頻數	百分比	有效百分比	累積百分比
無受教育或幼稚園	38	6.3	6.3	6.3
小學	104	17.1	17.2	23.5
初中 (中一至中三)	110	18.1	18.2	41.7
高中 (中四至中七／工業學院)	238	39.1	39.4	81.1
大專或以上（包括師範／大專／理工／大學等）	114	18.8	18.9	100.0
拒絕回答	4	0.7	缺值	
總計	608	100.0	100.0	

有效樣本 604 缺值樣本 4

INCOME 被訪者個人每月收入

	頻數	百分比	有效百分比	累積百分比
四千以下	5	0.8	1.5	1.5
四千至七千以下	40	6.6	12.1	13.6
七千至一萬以下	67	11.0	20.2	33.8
一萬至一萬四千以下	72	11.8	21.8	55.6
一萬四千至一萬七千以下	41	6.7	12.4	68.0
一萬七千至二萬以下	16	2.6	4.8	72.8
二萬至二萬四千以下	31	5.1	9.4	82.2
二萬四千至四萬以下	42	6.9	12.7	94.9
四萬或以上	17	2.8	5.1	100.0
收入不穩定	11	1.8	缺值	.
拒絕回答	21	3.5	缺值	
沒有收入	245	40.3	缺值	
總計	608	100.0	100.0	

有效樣本 331　　缺值樣本 277

SEX 被訪者性別

	頻數	百分比	有效百分比	累積百分比
男	287	47.2	47.2	47.2
女	321	52.8	52.8	100.0
總計	608	100.0	100.0	

有效樣本 608　　缺值樣本 0