Primary Healthcare Blueprint

Supplement

Health Bureau
The Government of the
Hong Kong Special Administrative Region
of the People's Republic of China

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PREFACE

Hong Kong has an effective and efficient public and private healthcare system of very high professional standard that delivers multi-level healthcare services. Nevertheless, facing the major challenges brought about by a rapidly ageing population and increasing prevalence of chronic diseases, the overloaded situation of the public healthcare services resulting in long waiting time will only be further aggravated without fundamental reform.

Over the past three years, the Coronavirus Disease 2019 (COVID-19) pandemic has further demonstrated the critical importance of a strong primary healthcare infrastructure and workforce within the community. At the same time, it has also exposed and exacerbated the financial burden on our healthcare system and the social costs of chronic diseases. A robust primary healthcare system will be an important line of defence against a wide range of potential public health crises.

It has been well said that 'an ounce of prevention is worth a pound of cure'. The Government is committed to enhancing district-based primary healthcare services in a bid to shift the emphasis of the present healthcare system and changing people's mindset from treatment-oriented to prevention-oriented. We are delighted that the establishment of District Health Centres (DHCs) in all districts in Hong Kong has progressively materialised.

The Government is determined to tackle the health challenges brought about by an ageing population and increasing chronic disease prevalence. This Blueprint aims to address the software and systemic aspect of our healthcare system, in terms of service delivery, governance, resources, manpower and technology. It also aims to map out the next steps towards establishing a primary healthcare system that can improve the overall health of the public and enhance their quality of life.

We strongly believe that the recommendations set out in this Blueprint will guide the direction of the development of our healthcare system that will enable us to support a sustainable and healthy system that backs up each and every citizen in Hong Kong in the decades to come. We look forward to joining hands with you towards building Hong Kong as an even healthier society.

Taking this opportunity, I would like to express my heartfelt gratitude to members of the Steering Committee on Primary Healthcare Development for their comprehensive analysis of the structural situation of our primary healthcare system and their constructive and invaluable recommendation to the Government. Their continued contribution is of paramount significance in the formulation of this Blueprint.

Professor Chung-mau LO, BBS, JP
Secretary for Health

PREAMBLE

The Steering Committee on Primary Healthcare Development (SCPHD) was set up in November 2017 to develop a blueprint for the sustainable development of primary healthcare services for Hong Kong (the Blueprint). Comprising primary healthcare experts from public and private sectors, SCPHD has provided advice on primary healthcare development from different aspects, namely manpower and infrastructure planning, collaboration model, community engagement, planning and evaluation framework and strategy formulation, with a view to formulating the Blueprint. With the progressive expansion of District Health Centre's services to 18 districts in Hong Kong, SCPHD has explored the development and service collaboration of a district-based primary healthcare system.

This Blueprint is developed based on the recommendations of SCPHD.

MEMBERSHIP OF THE STEERING COMMITTEE ON PRIMARY HEALTHCARE DEVELOPMENT

Chairperson
Secretary for Health

Non-official members (Surname in alphabetical order)
Professor CHAN Wing-kwong (from 1 December 2020)
Mr Philip CHIU Kwok-leung
Mr CHUA Hoi-wai
Dr LAM Ching-choi
Professor Cindy LAM Lo-kuen
Professor Gabriel Matthew LEUNG
Dr Donald LI Kwok-tung
Mr SHUM Ho-kit
Professor Hector TSANG Wing-hong
Professor Frances WONG Kam-yuet
Professor Samuel WONG Yeung-shan
Dr ZHU En (from 1 December 2017 to 30 November 2020)

Ex-officio members
Permanent Secretary for Health
Permanent Secretary for Labour and Welfare (*or representative*)
Director of Health (*or representative*)
Director of Home Affairs (*or representative*)
Commissioner for Primary Healthcare, Health Bureau (*or representative*)
Chief Executive, Hospital Authority (*or representative*)
Chief Manager (Nursing), Hospital Authority (*or representative*)

EXECUTIVE SUMMARY

Primary healthcare (PHC) is the first point of contact for individuals and families in a continuous healthcare process in the living and working community, which entails the provision of accessible, comprehensive, continuing, co-ordinated and person-centered care. A well-established and overarching PHC system routinely manages, maintains and enhances the health of the population at the community level, forms the foundation and portal of the pyramid of healthcare services, and serves as a gateway to specialised secondary and tertiary healthcare in hospital and institution settings. It is recognised as the most essential component in a well-functioning healthcare system.

2. In Hong Kong, the development of PHC could be traced back to the "Health For All, The Way Ahead": Report of the Working Party on Primary Health Care issued in 1990. The Report affirms the importance of PHC and provided a list of 102 recommendations toward its development. The Report has guided the development of the later policy and many of its recommendations are still being adopted today. In the subsequent years, a number of consultation documents were released by the Government, including the "Your Health, Your Life Consultation Document on Healthcare Reform" in 2008 and the "Our Partner For Better Health – Primary Care Development in Hong Kong: Strategy Document" in 2010.

3. Throughout the successive healthcare reform consultations, enhancement of PHC has been a common theme and key consensus. In particular, there is a consistent emphasis on the urgency and importance to foster primary healthcare amidst a rapidly ageing population, as potential solutions for the increasing demand of healthcare services and the overstretched public sector; and that a more strategic and effective use of private healthcare services through increasing scope of collaboration between public and private sectors should be adopted in healthcare service delivery especially for PHC.

4. To take forward PHC reform, the Steering Committee on Primary Healthcare Development (SCPHD) was set up in November 2017 to develop a blueprint for the sustainable development of PHC services for Hong Kong (the Blueprint). Comprising various experts and champions of PHC in both the public and private sectors, SCPHD has provided advice on PHC development from different aspects, namely manpower and infrastructure planning, collaboration model, community engagement, planning and evaluation framework and strategy formulation, with a view to formulating the Blueprint. With the progressive expansion of District Health Centre's (DHC) services to 18 districts in Hong Kong, SCPHD has explored the development and service collaboration of a district-based PHC system.

THE HEALTHCARE CHALLENGES IN HONG KONG

Ageing population and chronic disease prevalence

5. 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 from 2021 to 2030, with an average annual increase at 4.0% of the population aged 65 and over. 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.

6. Ageing is also associated with increasing health and social care needs and higher prevalence of chronic diseases. The percentage of persons who had chronic health conditions was 31% (around 2.2 million) in 2020/21, of which 47% were aged 65 and over. The number of Hospital Authority (HA) patients with chronic diseases is projected to reach 3 million in the coming decade by 2039. More alarmingly, there remains a substantial number of patients with chronic diseases – believed to be as many as a double – that remain undiagnosed and unmanaged. Among the most common types of chronic diseases, hypertension (HT) and diabetes mellitus (DM) are the highest in prevalence especially among the aged. Chronic diseases are a major public health concern because of their impact on quality of life and productivity of the economy due to gradually deteriorating health conditions of the poorly managed patients, as well as their heavy burden to the public healthcare system in terms of service utilisation, service cost and long term financial burden especially when the associated complications are not timely intervened.

7. 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 (A&E) 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 (FMSC) 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.

8. 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 PHC. Through well-managed and co-ordinated primary healthcare services at the 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.

Health system sustainability

9. Currently, treatment-oriented secondary and tertiary healthcare especially public hospital services accounted for the majority of healthcare services and spending in Hong Kong. According to the Domestic Health Accounts[1] (DHA), the total current health expenditure in Hong Kong is roughly split at 30:70 between PHC ($52.9 billion) and secondary/tertiary healthcare ($127.3 billion) in 2019/20. Owing to heavily subsidised public hospital services at over 97% of costs, public healthcare expenditure is even more concentrated with around 83% ($79.9 billion in 2019/20) of public health expenditure spent on secondary and tertiary healthcare whereas only 17% was spent on PHC ($16.0 billion in 2019/20).

10. Treatment-oriented healthcare induces higher healthcare costs and accelerates the increase of health expenditure. From 2010/11 to 2019/20, our average annual growth rate of public health expenditure was 5.6%, faster than that of GDP at 2.0% in real terms. According to the projection based on a research done in 2008 commissioned by the then Food and Health Bureau [1] estimated that total/public healthcare expenditure will increase from 5.3%/2.9% of GDP in 2004 to 7.1%/4.1% of GDP in 2020 if nothing was done to reform the healthcare system. Actual total/public healthcare expenditure (excluding COVID-19 expenditure) was estimated to be about 6.7%/3.6% of GDP in 2019/20 according to

[1] Figures of Domestic Health Accounts 2019/20 are adopted as the health cost distribution in 2020/21 has been affected by the COVID-19 pandemic and deviates from the normal trend.

the DHA, illustrating that various reforms over the years might have helped to curb the expenditure increase.

11. Having said that, the accelerating ageing of the population in the coming decade will on one hand further limit GDP growth and the budget for public health expenditure, and on the other hand increase the demand for public health spending. It is simply unsustainable to keep increasing public health expenditure to fund the public hospital system to cope with the ever-increasing healthcare demand, unless systemic reform to the healthcare system is introduced.

Publicly-funded primary healthcare services

12. Over the years, the Government has been providing publicly-funded PHC mainly through direct services of the Department of Health (DH) and HA. In recent years, the Government has launched various government-subsidised or public-private partnership (PPP) healthcare programmes as recommended in previous healthcare reform consultation documents with a view to tapping into the private healthcare sector resources in meeting the demand for public PHC service and enhancing the quality of health of the population. These include the Vaccination Subsidy Scheme (VSS) since 2008, Elderly Health Care Voucher (EHCV) Scheme since 2009, General Out-Patient Clinic PPP (GOPC PPP) Scheme since 2014, and Colorectal Cancer Screening Programme since 2016. Together government subsidised programmes accounted for some 3 billion fixed government expenditure on PHC in 2019/20.

13. To strengthen collaboration between the health and social care sectors and PPP in a district setting with a view to enhancing public awareness in disease prevention and self-health management, offering greater support for patients with chronic diseases, and relieving the pressure on specialist and hospital services, the Government is committed to enhancing district-based PHC services by setting up DHCs throughout the territory progressively since 2019. Operated by a non-government entity through government funding, the DHC is a brand new service model and will be a key component of the PHC system in a bid to shift the emphasis of the present healthcare system and people's mindset from treatment-oriented to prevention-oriented.

14. To build up a critical mass of district-based PHC services throughout the territory, the Government has set up DHCs (and DHC Expresses of smaller scale in the interim in all districts across the territory by 2022. DHCs will progressively strengthen their role as the co-ordinator of community PHC services and case manager to support PHC doctors on one hand, and their role as district healthcare 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 PHC and social service providers.

Private primary healthcare providers and public-private partnership

15. Complementing the public healthcare system, the private sector is the major provider of PHC services, accounting for about 75% of PHC expenditure and providing about 68% of out-patient doctor consultations. In 2019/20, about 77% of private health expenditure on PHC was paid out-of-pocket. While private services offer more choices and flexibility to patients, accessibility and equality of healthcare are constrained. Private PHC services are mainly provided as episodic care without co-ordination and continuity. Moreover, as only about 23% of the population have a designated family doctor, the role of family doctors on care co-ordination, streamlining and triage at the community level is limited.

16. To improve accessibility to quality PHC for the general public and redress the imbalance between the public and private healthcare sector, strategically the Government strives to optimise the utilisation of private healthcare resources and leverage on the private sector's capacity for providing PHC services, with a view to relieving pressure on the public sector and thereby enhancing the sustainability of the healthcare system. As recommended in the "Your Health, Your Life Healthcare Reform Consultation

Document" in 2008, PPP in healthcare should be pursued in Hong Kong to subsidise the community to make better use of resources in the private sector to deliver service for some public sector patients, thus allowing the public healthcare system to continue to serve as an essential safety net for the population and be accessible to those who lack the means to pay.

17. In doing so, there is a need for standardisation and assurance of the quality of PHC services across public and private service providers to ensure that the whole PHC system is driving towards the Government's overall PHC policy and delivering the intended health outcomes. Enhancement of performance monitoring tools, improvement on standardisation and transparency in the private PHC sector to unleash their potential in achieving continuity of care, care co-ordination and gate-keeping are some of the key issues to be addressed. With the participation of well-managed private PHC providers in the PHC system, we envisage to see improvements in the quality of health for individuals and the population as a whole.

OUR VISION FOR THE PRIMARY HEALTHCARE SYSTEM

18. A shift of healthcare focus from curative treatment to the prevention of diseases is necessary for addressing the new challenges to our healthcare system brought about by an ageing population and increasing chronic disease prevalence. We are committed to enhancing district-based PHC services in a bid to shift the emphasis of the present healthcare system and people's mindset from treatment-oriented to prevention-oriented through strengthening district-based PHC services across Hong Kong.

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

20. To achieve the above, our proposals should follow the following **strategies**:

(a) **Prevention-oriented:** to prevent and manage chronic diseases, especially diabetes mellitus (DM) and hypertension (HT);

(b) **Community-based:** enhance and consolidate PHC resources at the community level;

(c) **Family-centric:** provision of accessible, comprehensive, coherent and co-ordinated care in the context of family and community; and

(d) **Early identification and intervention:** enhance screening of chronic diseases at the community level and streamline referral mechanism through the PHC system.

PRIMARY HEALTHCARE REFORM PROPOSALS

21. To achieve our vision of a sustainable healthcare system and to address the above challenges, we plan to undertake the following reform proposals –

(a) **Develop a Community-based Primary Healthcare System (Chapter 2)**

(b) **Strengthen Primary Healthcare Governance (Chapter 3)**

(c) **Consolidate Primary Healthcare Resources (Chapter 4)**

(d) **Reinforce Primary Healthcare Manpower (Chapter 5)**

(e) **Improve Data Connectivity and Health Surveillance (Chapter 6)**

22. To meet the challenges of the PHC system, not only do we need to introduce reform to the existing healthcare services and market structure, but we also need to reform the financing arrangements in support of the healthcare system reform as a whole to develop a sustainable and prevention-oriented PHC system. **These reform proposals form an integral package and complement each other.**

Chapter 2 - Develop a Community-based Primary Healthcare System

23. The current PHC system is fragmented with lack of overall strategic planning and co-ordination on service development and vertical and horizontal integration. Fragmentation in the health system results in inefficiencies in resource use and misalignment of incentives. **The Government recognises the need to establish a more systematic and coherent platform to incentivise the community to manage their own health, promote awareness of the importance of PHC services and improve service accessibility.** With the continuous development of DHC across the territory, the PHC service delivery model in Hong Kong will be gradually evolved into a district-based community health system with a view to triggering a paradigm shift of the present healthcare system and people's mindset from treatment-oriented to prevention-oriented. To enhance PHC service delivery, we recommend to consider the following -

(a) **To further develop a district-based family-centric community health system based on the DHC model** with an emphasis on horizontal integration and co-ordination of district-based PHC services through service co-ordination, strategic 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, as well as strengthening the concept of "family doctor for all", especially in the management of chronic diseases, tocultivate a long-term family doctor-patient relationship between the patient and his/her family doctor. **(Recommendation 2.1)**

(b) **To progressively migrate PHC services under DH to the district-based community health system**, especially those with room for more efficient delivery through an alternative approach, with a view to facilitating provision ofintegrated PHC services through the district-based community health system and reducing service duplication. **(Recommendation 2.1)**

(c) **To introduce a "Chronic Disease Co-Care Scheme" (CDCC Scheme)** to provide targeted subsidy for the public to conduct diagnosis and management of target chronic diseases (especially hypertension (HT) and diabetes mellitus (DM)) in the private healthcare sector through "family doctor for all" and a multi-disciplinary public-private partnership model. **(Recommendation 2.2)**

(d) **To review the positioning of HA's GOPC services to take priority care of the socially disadvantaged population groups (especially low income families and the poor elderly** while other patients may also choose to seek private PHC services through the CDCC Scheme. **(Recommendation 2.3)**

Chapter 3 - Strengthen Primary Healthcare Governance

24. The existing health governance structure has not placed enough emphasis on PHC. A holistic approach at the policy level is required in addressing the systemic imbalances between PHC and secondary/tertiary healthcare in terms of policy-making, financing, manpower, regulation and outcome monitoring. A co-ordinated approach at the implementation level is also required to ensure commitment to drive institutional changes and enhance cross-sectoral and inter-organisational co-ordination among PHC services in an integrated manner. Enhancement of performance monitoring tools, and improvement on standardisation and transparency in the services across the public sector and the private sector, where PHC services mainly take place, are some of the key issues to be addressed. To strengthen PHC governance, we propose the following -

(a) **To progressively transform the Primary Healthcare Office (PHO) currently under the Health Bureau (HHB) into the Primary Healthcare Commission** empowered to oversee PHC service delivery, standard setting, quality assurance and training of PHC professionals under one roof, as well as to take on PHC service planning and resource

allocation through strategic purchasing supported by Strategic Purchasing Office (SPO). **(Recommendation 3.1)**

(b) **To require all family doctors and healthcare professionals participating in PHC service provision to be enlisted on the Primary Care Register (PCR) and commit to using the PHC reference frameworks (RFs)**, including those enrolling in government-subsidised programmes such as the EHCV Scheme and various PHC PPP Programmes such as CDCC Scheme, in order to ensure the quality of PHC services, establish the "gold standard" for PHC service providers, and provide incentives for PHC professionals to participate in multi-disciplinary PHC services and adopt best practices. **(Recommendation 3.2)**

(c) **To establish the two-way referral mechanism between PHC service providers in both the public and private sectors with the specialist and hospital services**, emphasising the effective discharge of case management and gate-keeping role of PHC service providers, allowing timely and appropriate referral of patients with complications by PHC doctors to specialists and hospitals for secondary care, and allowing continuing follow-up, monitoring and diseases management of patients in stable conditions by primary care doctors. **(Recommendation 3.3)**

Chapter 4 - 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 PHC, apart from injecting new resources through increasing public expenditure, we need to explore reallocation from and better utilisation of existing resources. To consolidate resources for PHC, we will explore the following initiatives –

(a) **Make wider use of market capacity and adopt the "co-payment" principle to provide government subsidised PHC programmes**. This will incentivise citizens with higher affordability to use private healthcare services under government subsidized programmes. **(Recommendation 4.1)**

(b) **To improve EHCV Scheme to direct resources towards PHC services with an emphasis on strengthening chronic disease management and reinforcing the different levels of prevention**, by incentivising elders to use EHCVs for continuous preventive healthcare and chronic disease management with healthcare service providers registered under the PCR, such as health assessment, chronic disease screening and management or other government initiatives. **(Recommendation 4.2)**

(c) **To establish SPO under HHB to oversee the development and implementation of strategic purchasing programmes at primary care level**, so as to channel resources more effectively towards quality, co-ordinated and continuous PHC with an emphasis on prevention-oriented, community-based and family-centric services, reduce service duplications, gaps, inefficiencies and mismatches between the public and private sectors in PHC, and ultimately bring about optimised co-ordinated and integrated care to individuals and families to maximise their health benefits and outcomes.
(Recommendation 4.3)

(d) **To enhance coordination of development and redevelopment of government buildings and premises for healthcare facilities at the community level** , in order to enhance utilisation of land resources and workspace for the delivery of seamlessly integrated, co-ordinated and coherent PHC through co-location. **(Recommendation 4.4)**

Chapter 5 - Reinforce Primary Healthcare Manpower

26. The sustained delivery of quality and adequate PHC services relies on the stable and sufficient supply of qualified PHC manpower with sufficient knowledge, skills and attitude, who embraces the concept of multi-disciplinary teamwork and specialises in the team setting in PHC in the community. The training of PHC professionals and enhancing the role of PHC professionals are therefore essential to ensure adequate quantity and quality of manpower supply. Specifically, we recommend the following –

(a) **To review the manpower projection model and formulate strategies to systematically project the demand for PHC professionals** taking into account healthcare demands of the population as a whole, the recommendations in the Blueprint, and provision of PHC services in both the public and private sectors, with a view to ensuring a sufficient supply of PHC professionals through provision of subsidised local training places as well as attraction of non-locally trained professionals. **(Recommendation 5.1)**

(b) **To enhance PHC-related training for all PHC service providers and to set training requirements under PCR**, to facilitate healthcare professionals in both the public and private sectors to play a more active role in the development of PHC under a team approach and operate in a co-ordinated fashion as part and parcel of the district-based community health system. **(Recommendation 5.2)**

(c) **To progressively enhance the role of Chinese Medicine Practitioners (CMPs), Community Pharmacists as well as other PHC professionals in the delivery of PHC services,** through undergraduate and postgraduate education and clinical practice in PHC, and professional-driven and evidence-based development of care models and protocols under the aegis of the Primary Healthcare Commission with necessary resource allocation and referral pathways as part of the co-ordinated and coherent PHC at community level. **(Recommendation 5.3 and 5.4)**

Chapter 6 - Improve Data Connectivity and Health Surveillance

27. A comprehensive and effectively connected digital healthcare data network, which allows real-time access and sharing of health records is essential for facilitation and co-ordination of continuing 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. To improve data connectivity and health surveillance, we propose the following –

(a) **To transform the 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 PHC-related services**, with multiple function layers to facilitate service record keeping, essential data sharing (such as allergies history, 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. **(Recommendation 6.1 and 6.2)**

(b) **To require all PHC service providers to use eHealth and input the medical data, essential health and service data of service users into the eHealth account of the service users**, with a view to strengthening the protection for healthcare service users, ensuring healthcare quality and raising standards, and enhancing co-ordination and continuity in the healthcare process especially PHC at the community level and referral to and from the public hospital system, through mandates by necessary amendments to the Electronic Health Record Sharing System Ordinance (Cap. 625) and inclusion of relevant requirements in PCR and PPP programmes. **(Recommendation 6.1)**

(c) **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 pattern, etc.**, with a view to providing the necessary data, evidence and analysis to support health policy making by the Government, especially in supporting PHC 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. **(Recommendation 6.3)**

A SUCCESSFUL A PRIMARY HEALTHCARE SYSTEM

28. The COVID-19 pandemic has presented exceptional challenges to public health system around the world. Hong Kong is no exception. To maintain the remarkable efficiency, professionalism and high adaptability of the healthcare system in Hong Kong, we need to make continuous improvements in multiple aspects in order to tackle the challenges posed to our healthcare services by an ageing population and the epidemic.

29. The COVID-19 pandemic has further highlighted the critical importance of a strong community-based PHC system. This Blueprint sets out our vision and outlines the specific recommendations and implementation plans to lay down a strategic roadmap for the future development of PHC in Hong Kong.

30. The successful development of PHC 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 to be established under HHB shall develop a mechanism including 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 PHC proposals.

WAY FORWARD

31. In accordance with the Blueprint recommendations, we shall proceed to engage with stakeholders to formulate detailed plans and implementation timetable with the support of SCPHD. We expect to initiate some of the plans in phases over the short, medium and long term.

KEY RECOMMENDATIONS

DEVELOP A COMMUNITY-BASED PRIMARY HEALTHCARE SYSTEM

- To further develop a district-based family-centric community health system based on the District Health Centre model
- To further strengthen the concept of "Family Doctor for All" especially in matters concerning chronic disease management
- To progressively migrate primary healthcare services under Department of Health to the district-based community health system
- To introduce a "Chronic Disease Co-Care Scheme" (CDCC Scheme) to provide targeted subsidy for the public to conduct diagnosis and management of target chronic diseases (especially HT and DM)
- To review the positioning of the General Out-patient Clinics of the Hospital Authority to take priority care of the socially disadvantaged groups (especially low income families and the poor elderly)

STRENGTHEN PRIMARY HEALTHCARE GOVERNANCE

- To progressively transform the Primary Healthcare Office currently under the Health Bureau into a Primary Healthcare Commission
- To require all family doctors and healthcare professionals participating in primary healthcare service provision to be enlisted on the Primary Care Register and commit to using the primary healthcare reference frameworks
- To establish the two-way referral mechanism between primary healthcare service providers in both the public and private sectors with the specialist and hospital services

CONSOLIDATE PRIMARY HEALTHCARE RESOURCES

- To make wider use of "co-payment" principle to implement government subsidised primary healthcare programmes
- To improve the Elderly Health Care Voucher Scheme to direct resources towards primary healthcare services with an emphasis on strengthening chronic disease management and reinforcing the different levels of prevention
- To set up a Strategic Purchasing Office under the Health Bureau to oversee the development and implementation of strategic purchasing programmes at primary care level
- To enhance coordination of development and redevelopment of government buildings and premises for healthcare facilities at the community level

REINFORCE PRIMARY HEALTHCARE MANPOWER

- To review the manpower projection model and formulate strategies to systematically project the demand for primary healthcare professionals
- To enhance primary healthcare training for all primary healthcare service providers and to set training requirements under Primary Care Register
- To progressively enhance the role of Chinese Medicine Practitioners, Community Pharmacists as well as other primary healthcare professionals in the delivery of primary healthcare services

IMPROVE DATA CONNECTIVITY AND HEALTH SURVEILLANCE

- To transform the eHealth into a comprehensive and integrated information infrastructure for healthcare data sharing, service delivery and process management especially primary healthcare services
- To require all primary healthcare service providers to use eHealth and input the medical data, essential health and service data of service users into the eHealth account of the service users
- To develop a population-based health dataset conduct on-going data analytics and surveys and commission research studies on population-based health status, disease pattern and burden, and health seeking pattern, etc.

OUR VISION FOR THE PRIMARY HEALTHCARE SYSTEM

A shift in healthcare focus from curative treatment to the prevention of diseases is necessary for addressing the new challenges of our healthcare system brought about by an ageing population and increasing chronic diseases prevalence. We are committed to enhancing district-based primary healthcare (PHC) services in a bid to shift the emphasis of the present healthcare system and people's mindset from treatment-oriented to prevention-oriented.

Our **vision** for the Blueprint is to improve the overall health of the population, provide accessible and coherent healthcare services and establish a sustainable healthcare system.

2. Our **mission** is to –

   (a) **shift** the emphasis of the present healthcare system and people's mindset from treatment-oriented institution-centric secondary/tertiary healthcare to prevention-oriented family-centric PHC; and

   (b) **enhance** co-ordination among various sectors and across different levels of care, and strengthen district-level PHC services in the community.

3. To achieve the above, we should follow the following strategies –

   (a) **Prevention-oriented**: to prevent and manage chronic diseases, especially diabetes mellitus (DM) and hypertension (HT);

   (b) **Community-based**: to enhance and consolidate primary healthcare resources at the community level;

   (c) **Family-centric**: provision ofto provide accessible, comprehensive, coherent, co-ordinated care in the context of family and community; and

   (d) **Early identification and intervention**: to enhance screening of chronic diseases at the community level and streamline referral mechanism through the PHC system.

4. In addition, in proposing reforms in the PHC system, it is necessary that we adhere to the following **guiding principles**, which form the cornerstone of our healthcare system –

   (a) maintain the public healthcare system **as a safety net** for the low-income and under-privileged groups and those in need so as to uphold our long-established healthcare policy that **no one should be denied adequate healthcare due to a lack of means**;

   (b) ensure that **necessary healthcare services remain accessible and affordable** to the community; and

   (c) upkeep the **highest healthcare standards** in our healthcare professionals.

CHAPTER

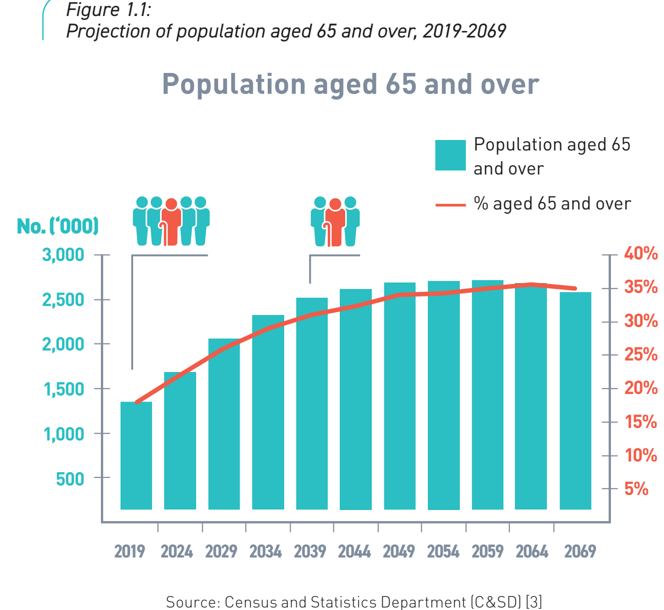
THE HEALTHCARE CHALLENGES IN HONG KONG

With longer life expectancy, we all wish people to stay healthy longer. However, our healthcare system is overly treatment-oriented and the public healthcare system is over-burdened. With the most rapidly ageing of our population in the upcoming decade, our healthcare system is vulnerable and its sustainability is threatened. **We see a pressing need to review the health system to promote and protect people's health and well-being.**

Ageing Population and Increase in Chronic Disease Prevalence

5. Like many other places, Hong Kong is facing major challenges brought on by a rapidly ageing population and an increase in the prevalence of chronic diseases. **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 [2, 3]. 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 [3]. 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 [3]. Meanwhile, the elderly dependency ratio[2] will double in 2039 [3]. With more than one in three elderlies either living alone or with only an elderly partner [4], social support and carer support for them in the coming decades will be a critical concern.

Figure 1.1:
Projection of population aged 65 and over, 2019-2069



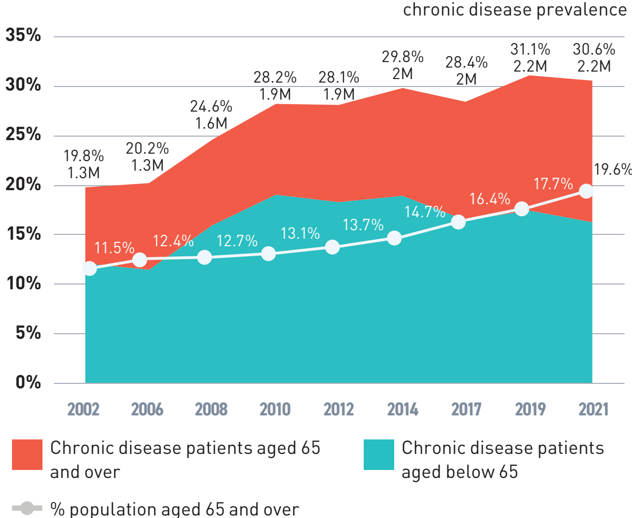
Source: Census and Statistics Department (C&SD) [3]

[2] The number of elderly aged 65 and over per 1 000 persons aged 15 to 64

6. 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 [5]. **The number of Hospital Authority (HA) patients with chronic diseases[3] 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 [6].

Figure 1.2:
Ageing population and chronic disease prevalence, 2002-2021

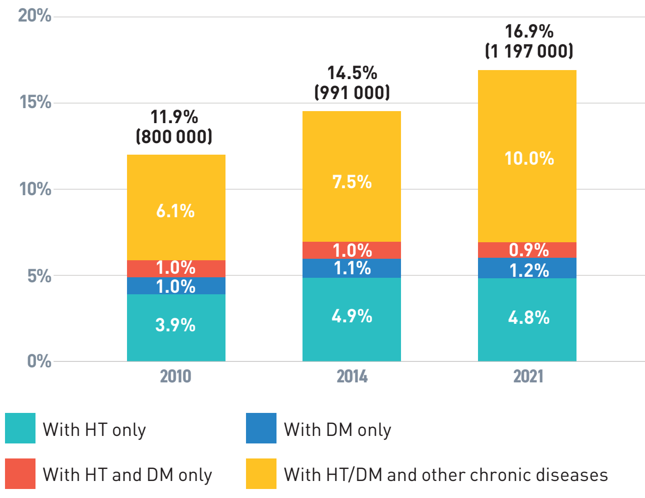
Ageing population and chronic disease prevalence



Source: C&SD and Thematic Household Survey Reports No. 12, 30, 41, 45, 50, 58, 63, 68 and 74[2, 5]

Figure 1.3:
Proportion of population with HT and/or DM, 2010-2021

Proportion of population with HT and/or DM



Source: Thematic Household Survey Reports No. 45, 58 and 74 [5]

7. About 55% of deaths in Hong Kong are attributable to chronic diseases in 2020 such as HT, heart disease, DM and chronic respiratory problems. Among the most common types of chronic diseases, HT and DM are the highest in prevalence especially among the aged [6].

8. **Chronic diseases are a major public health concerns because of their impact** on quality of life and productivity of the economy due to gradually deteriorating health conditions of the poorly managed patients, as well as their heavy burden to the public healthcare system in terms of high service utilisation and financial cost, especially when the associated complications are not timely intervened. For instance –

    (a) Service utilisation: In 2019/20, for non-cancer chronic disease patients under treatment in the HA's out-patient settings, namely the General Out-patient Clinics (GOPCs), Family Medicine Specialist Clinics (FMSCs) and Specialist Out-patient Clinics (SOPCs), **82% of them had**

[3] 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.

[4] Including Coronary Heart Disease, Stroke, Chronic Heart Failure and stage 3a to stage 5 Chronic Kidney Disease

Figure 1.4:
Utilisation of GOPC, FMSC and SOPC

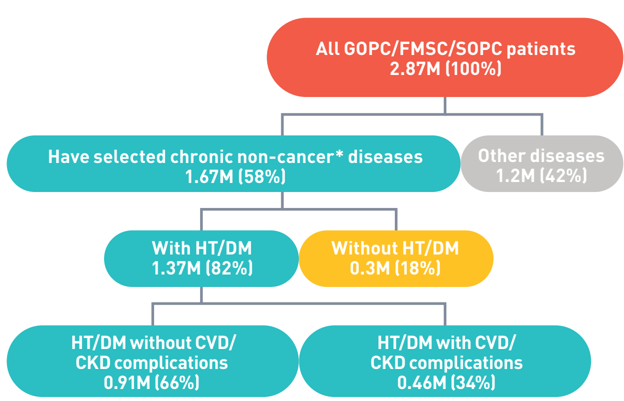


Figure in ( ) denotes % share of the previous tier

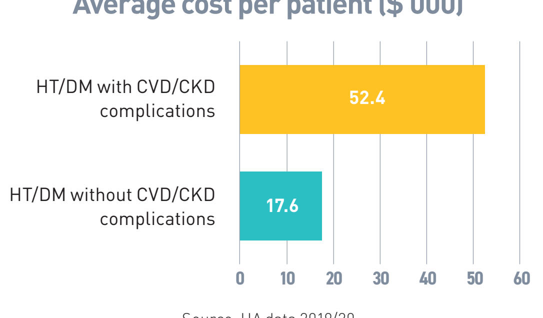
*Chronic disease status of patients as of 2020-03-31. The selected non-cancer chronic diseases include hypertension (HT), diabetes mellitus (DM), hyperlipidemia (LIPID), CVD (coronary heart disease, stroke, chronic heart failure), chronic kidney disease stage 3A-5 (CKD), glaucoma, osteoporosis (proxied by hip fracture), chronic obstructive pulmonary disease, hepatitis B, depression, dementia, and Parkinsonism.

Source: HA data 2019/20

HT/DM. Among this group, about one-third had cardiovascular disease (CVD) or chronic kidney disease (CKD)[4], complications that are associated with HT/DM;

(b) Service cost: The annual average **HA service cost in 2019/20 for patients with HT/DM and related CVD/CKD complications was almost two times higher** than patients with HT/DM but without complications; and

Figure 1.5:
Average HA service cost per patient



Source: HA data 2019/20

(c) Financial burden: Among patients in the top decile of annual average HA service cost in 2019/20, **60% of them had HT/DM**.

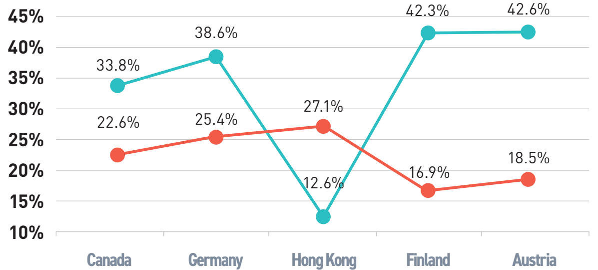
Health System Sustainability

9. Hong Kong's healthcare system is underpinned by a robust public sector and a burgeoning private sector which operate along a dual-track. Public healthcare service is the cornerstone of Hong Kong's healthcare system, acting as a safety net for the entire community, while the private healthcare sector provides personalised choices and more convenient services to those who are willing and may afford to pay for private healthcare services.

10. The public sector dominates secondary and tertiary care, accounting for about 63% of the health expenditure of these two tiers combined. It is financed by the Government and its healthcare services are mainly delivered through the Department of Health (DH) and Hospital Authority (HA) [7]. Public healthcare services are heavily subsidised and hence are highly affordable. Details of the healthcare system in Hong Kong is illustrated in **Appendix A**.

11. Hong Kong has one of the lowest healthcare expenditure as a percentage of GDP amongst advance economies with comparably demographic profile. In 2019, public health expenditure as a percentage of tax revenue in Hong Kong was among the highest in the world at about 27.1%, while tax revenue as a percentage of GDP was among the lowest at about 12.6% [7, 8]. This is a strong evidence that the healthcare system in HK, despite the increasing expenditure in tandem with the rapidly ageing population, remains a highly cost-effective and efficient one, insofar as it can still deliver healthcare services to meet the needs of the population and maintain HK as having one of the longest life expectancy and lowest infant mortality around the world. However, **it is simply unsustainable to keep increasing public health expenditure to fund the public hospital system to cope with the ever-increasing healthcare demand, unless systemic reform to the healthcare system is introduced.**

Figure 1.6:
Tax revenue to GDP and public health expenditure to tax revenue in selected economies with similar GDP per capita, 2019/20

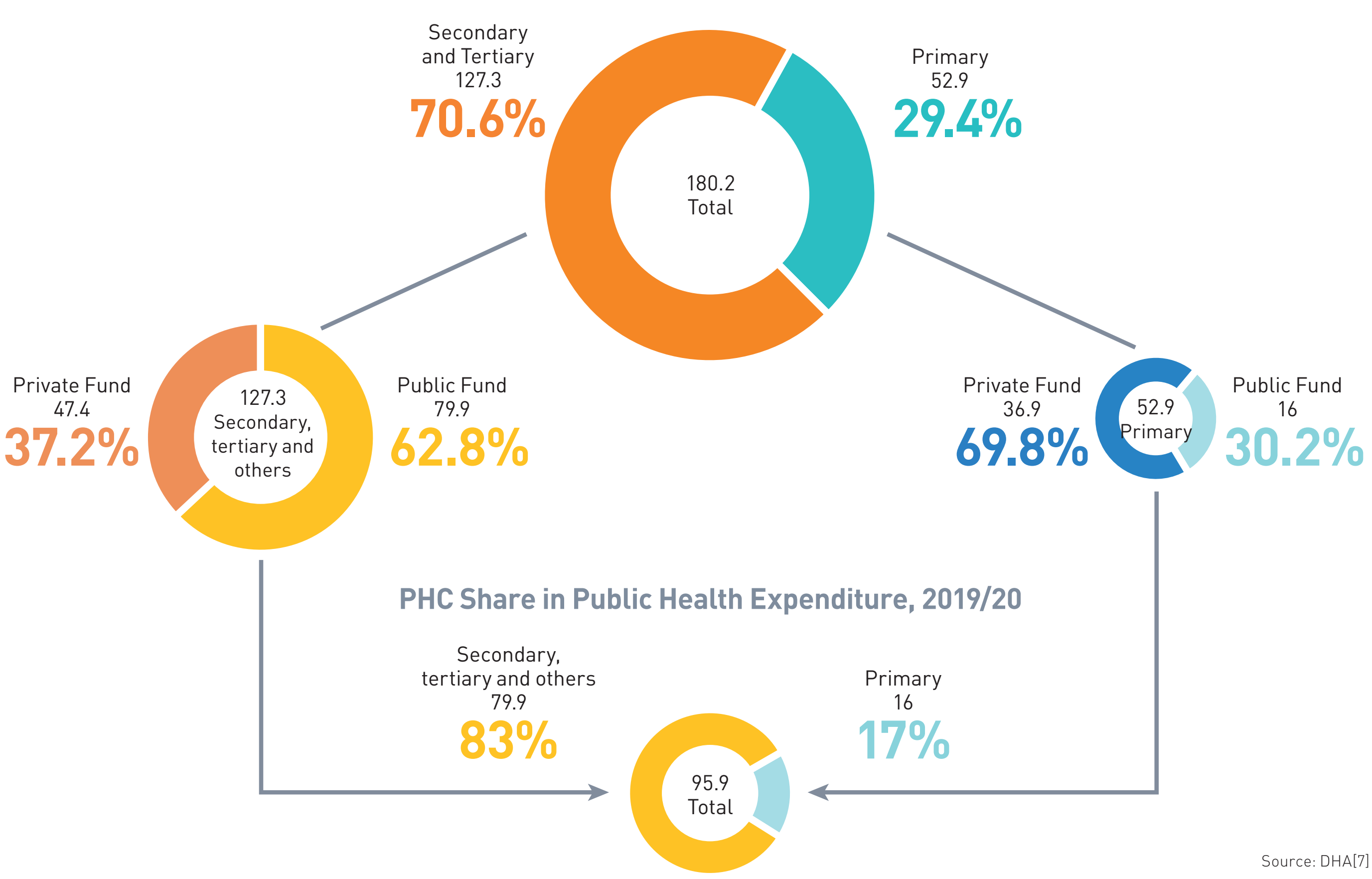


Source: OCED, Domestic Health Accounts (DHA) [7, 8]

12. There is no set global standard for the percentage of health expenditure that a health system should be spending on PHC. That said, across the 88 countries analysed in the 2019 WHO "Global Spending on Health: A World in Transition" report, PHC spending ranged from 33% to 88% of health spending, with a global 54% average across the 88 countries.

13. Currently, treatment-oriented secondary and tertiary healthcare especially public hospital services accounted for the majority of healthcare services and spending in Hong Kong. According to the 2019/20 DHA, the total health expenditure in Hong Kong is roughly split by 30:70 between PHC ($52.9 billion) and secondary/tertiary healthcare ($127.3 billion) which is much lower than the average expenditure of 54% across 88 countries as aforementioned. Owing to heavily subsidised public hospital services at over 97% of costs, public healthcare expenditure is even more concentrated with around 83% ($79.9 billion) of public health expenditure spent on secondary and tertiary healthcare whereas only 17% was spent on PHC ($16.0 billion) [7].

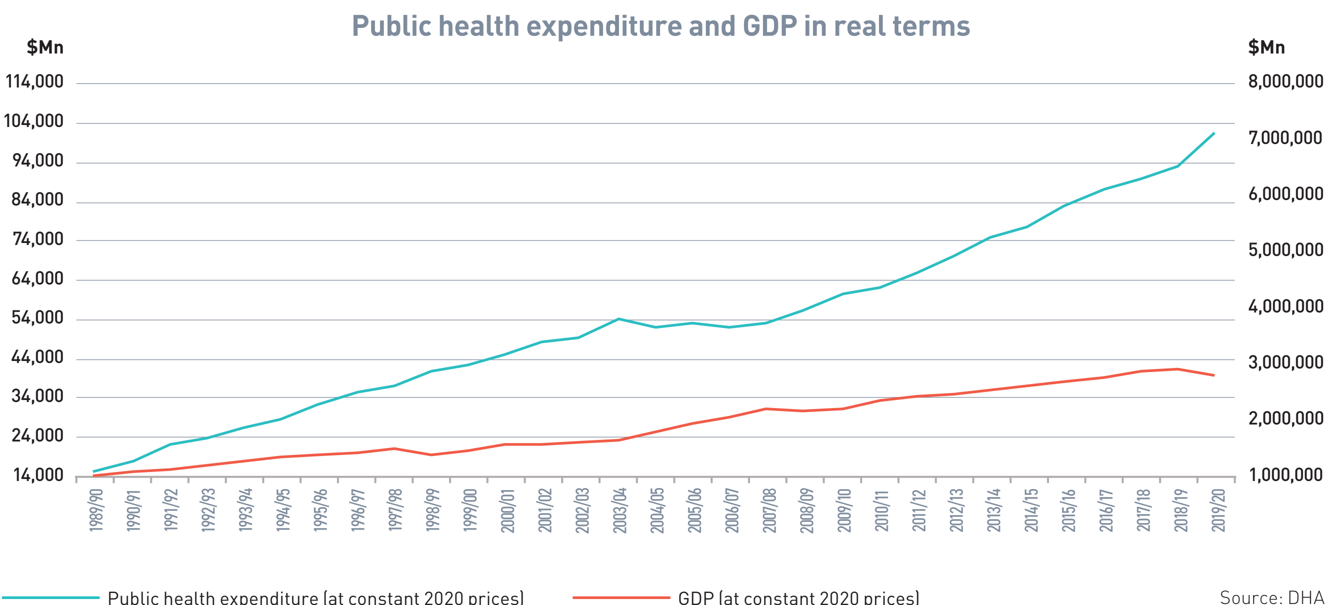
Figure 1.7:
Composition of current health expenditure



Source: DHA[7]

14. Treatment-oriented healthcare induces higher healthcare costs and accelerates the increase of health expenditure. Over the past three decades, both public health expenditure and private health expenditure have been increasing in parallel. More worryingly, health expenditure growth has been exceeding economic growth. From 2010/11 to 2019/20, our average annual growth rate of public health expenditure was 5.6% faster than that of GDP at 2.0% in real terms [7]. According to the projection based on a research done in 2008 commissioned by the then Food and Health Bureau [1], it was estimated that total/public healthcare expenditure will increase from 5.3%/2.9% of GDP in 2004 to 7.1%/4.1% of GDP in 2020 if nothing was done to reform the healthcare system. Actual total/public healthcare expenditure (excluding COVID-19 expenditure) was estimated to be about 6.7%/3.6% of GDP in 2019/20 according the Domestic Health Accounts, illustrating that various reforms over the years might have helped to curb the expenditure increase. Having said that, the accelerating ageing of the population in the coming decade will on the one hand further limit GDP growth and the budget for public health expenditure, and on the other increase the demand for public health spending.

Figure 1.8:
The growth of public health expenditure and GDP in real terms



Source: DHA

15. Hong Kong's public healthcare system has posed a threat to sustainability. **The growth of public health expenditure and current health expenditure has been largely exceeding the growth of GDP over the previous decade** [7]. The situation will be further aggravated with the rapid ageing of the population and the rising chronic disease prevalence in the upcoming decade. Our healthcare system will not be sustainable unless a systemic change is being introduced. **A more strategic allocation of public health expenditure is critical.**

Public Healthcare System at Risk

16. Over the years, we have developed an enviable public healthcare system in Hong Kong which provides quality, reliable, equitable and affordable healthcare services. However, heavily subsidised at about 97% [9], the public health system is overloaded with long waiting time [10].

17. Ageing population and increasing chronic diseases prevalence is expected to exert a heavy toll on secondary/tertiary care especially the public

hospital system. 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 (A&E) admissions, and over one-third of GOPC and SOPC attendances in 2019. According to HA, the per capita hospital utilisation rate for chronic disease patients was three times that of the general population in 2019, and their healthcare costs are generally higher than those of overall HA patients.

18. The burden on public secondary healthcare services is heavy. In addition to a highly subsidised public healthcare system, phenomena such as unclear patient pathway and absence of an effective and evidence-based gate-keeping mechanism by PHC add on to the problem. The waiting time for public SOPC services is long and doctors' caseload is heavy [10], for instance –

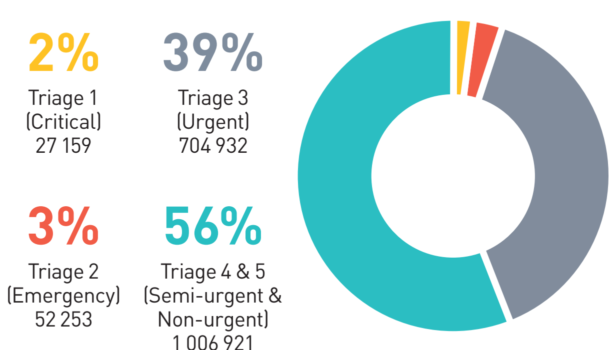
(a) In 2020/21, SOPCs served 7.5 million attendances, among which 0.54 million were first attendances in the eight major specialties[5]. Of these first attendances, 16% were from private doctors. 46% of the referrals among all specialties from private doctors were stable cases, instead of urgent cases or semi-urgent cases;

(b) In 2021/22, in the 90th percentile of stable new SOPC cases in the Medicine specialty, the waiting time was 122 weeks;

(c) In 2021/22, each doctor was serving 5 680, 2 561, and 2 306 follow-up attendances in Ophthalmology; Ear, Nose and Throat; and Psychiatry (i.e. the top three specialist areas with the highest follow-up attendances per doctor); and

(d) In 2021/22, in A&E departments, around 56% of the first attendances were semi-urgent and non-urgent.

Figure 1.9: A&E first attendance in 2021/22



Source: HA data 2021/22[10]

19. Faced with both an ageing population and an increase in chronic disease prevalence, the health and social care needs of our community will increase significantly in the coming years. 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 PHC. Through well-managed healthcare 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.

Potentials of the Private Primary Healthcare Sector and public-private partnership

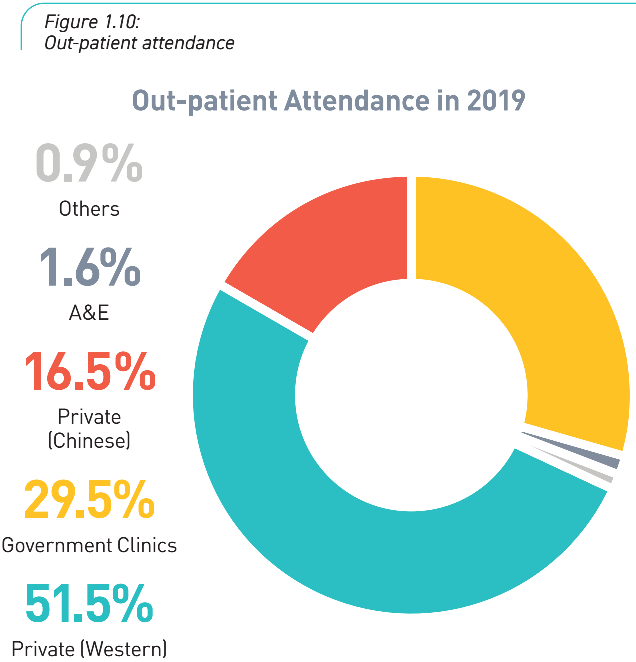
20. Complementing the public healthcare system, the private sector is the chief provider of PHC, accounting for about 68% of the out-patient doctor consultation market in Hong Kong [5, 7]. Primary care in the private sector comprises a wide selection of private service providers. They include general and specialist clinics as well as Chinese Medicine (CM) clinics, dental clinics, community pharmacies,

[5] Namely, medicine, surgery, gynaecology, paediatrics, orthopaedics and traumatology, ears, nose, and throat (ENT), ophthalmology and psychiatry

diagnostic centres, medical laboratories, optical shops, etc. **Choice is a cornerstone in private services.** Patients, at their own expenses (with some under private insurance coverage), are free to choose their preferred doctors and other service providers according to their own needs and preferences. Other advantages over the public healthcare system include shorter waiting time, better environment, more convenient service locations, and more personal and tailored services where necessary.

21. The private sector, funded mainly by private funds, is the major provider of PHC services, accounting for about 75% of PHC expenditure and about 68% of out-patient doctor consultations. In 2019/20, about 77% of private health expenditure on PHC was paid out-of-pocket [5, 7].

Figure 1.10:
Out-patient attendance



Source: Thematic Household Survery Report No. 68[5]

22. However, accessibility and equality of healthcare in the private sector are constrained. The low income and underprivileged groups regard private PHC services as unaffordable for regular visit [11]. Private PHC services are mainly provided as episodic care without co-ordination and continuity. Their functions in continuity of care, care co-ordination and gate-keeping, as well as price transparency are subject to challenges.

23. Moreover, as only about 23% of the population have a family doctor [5], the role of family doctors in care co-ordination, streamlining and triage of services at the community level is hampered. With the healthcare pathway unclear and protocol-driven PHC inadequate, misalignment and ineffective use of primary and secondary healthcare services become evident. Patients often approach multiple points of contact in the healthcare process among the primary and secondary healthcare services before arriving at the right place. Doctor shopping is common, with 26% to 40% of patients consulting different doctors for the same illness episode [12, 13].

24. The above evidence suggests that, with better co-ordination, resource allocation and policy steer, the potentials of the private PHC sector in addressing the healthcare challenges in Hong Kong today as outlined above would be immense. **We need to further enhance public-private collaboration and optimise the use of private healthcare resources to support a sustainable healthcare system.**

PRIMARY HEALTHCARE REFORM PROPOSALS

25. To achieve our vision of a sustainable healthcare system and to address the above challenges, **we plan to undertake the following reform proposals –**

(a) Develop a Community-based Primary Healthcare System (Chapter 2)

(b) Strengthen Primary Healthcare Governance (Chapter 3)

(c) Consolidate Primary Healthcare Resources (Chapter 4)

(d) Reinforce Primary Healthcare Manpower (Chapter 5)

(e) Improve Data Connectivity and Health Surveillance (Chapter 6)

26. To meet the challenges of the PHC system, not only do we need to introduce reform to the existing healthcare services and market structure, we also need to reform the financing arrangements in support of the healthcare system reform as a whole. **These reform proposals form an integral package and complement each other** to help develop a sustainable and prevention-oriented family-centric primary healthcare system.

CHAPTER

DEVELOP A COMMUNITY-BASED PRIMARY HEALTHCARE SYSTEM

The current PHC system is fragmented with a lack of overall strategic planning and co-ordination on service development and vertical and horizontal integration. Fragmentation in the health system results in inefficiencies and misalignment with the use of resources. **The Government recognises the need to establish a more systematic and coherent platform to incentivise the community to manage their own health, promote awareness of the importance of PHC services and improve service accessibility.** With the continuous development of District Health Centres (DHCs) across the territory, the PHC service delivery model in Hong Kong will gradually evolve into a district-based family-centric community health system. Efforts are made with a view to triggering a paradigm shift in the present healthcare system and people's mindset from treatment-oriented to prevention-oriented.

27. In 1978, The World Health Organisation (WHO) passed The Declaration of Alma Ata, which recognises PHC as the key to "Health for All" [14]. This declaration sets the scene for international efforts to promote PHC and formally acknowledges the pivotal role of a robust PHC system.

28. As discussed in Chapter 1, in the recent decades, Hong Kong and other countries in the world alike are facing similar healthcare challenges: ageing population, increase in chronic disease prevalence, increase in healthcare demand, decrease in elderly support ratio, more complex health needs, inadequate healthcare manpower and financial resources, and growing public discontent towards healthcare in both quality and quantity. The latest report of the Global Burden of Diseases reveals that, **from 1990 to 2019, the cause of disease burden has shifted from communicable diseases to chronic diseases.** It also correlates with broader determinants of health, such as people's income, education level and population structure [15].

29. To address these challenges, a new shift of focus from life-saving treatments to the prevention of chronic diseases with whole-of-society co-ordinated effort is needed. **According to the WHO, evidence has shown that PHC is the most equitable, efficient and effective strategy to enhance the health of populations.** In addition, there is considerable evidence that health systems based on PHC services have better health outcomes [16]. A brief introduction on the latest planning of PHC in five selected places, namely, Mainland China, United Kingdom, Singapore, Australia and New Zealand is set out in Appendix B.

PRIMARY HEALTHCARE DEVELOPMENT IN HONG KONG

30. In Hong Kong, the development of PHC could be traced back to 1990 with the report entitled "Health for all, the way ahead: Report of the Working Party on Primary Health Care". As indicated in

the Report, **PHC is the first point of contact for individuals and families in a continuing healthcare process which entails the provision of accessible, comprehensive, continuing, co-ordinated and person-centred care in the context of family and community [17]**. The Report comprehensively reviewed the development and challenges of healthcare services in Hong Kong and the worldwide development of PHC as the strategy to achieving WHO member-states' target of "health for all" and recommended a host of strategies focusing on PHC, many of which are still being adopted today.

31. The Report has guided the development of the later policy and consultation documents for the development of PHC and many of its recommendations are still being adopted today. In the subsequent years, a number of consultation documents released by the Government, including the "Your Health Your Life-Consultation Document on Healthcare Reform" in 2008 and the "Our Partner for Better Health – Primary Care Development in Hong Kong: Strategy Document" in 2010, have all reaffirmed the need to shift from secondary to PHC as the direction of healthcare reform. An introduction of the development of PHC in Hong Kong is set out in **Appendix C**.

32. Over the years, the Government has been providing publicly-funded PHC services mainly through direct services of DH and HA. It also subsidises non-governmental organisations (NGOs) in providing PHC and social services. In recent years, the Government has launched various government-subsidised or public-private partnership (PPP) healthcare programmes as recommended in previous healthcare reform consultation documents with a view to tapping into the private healthcare sector resources in meeting public PHC service demand and enhancing the quality of health of the population and healthcare services for them. These include the Vaccination Subsidy Scheme (VSS) since 2008, Elderly Health Care Voucher (EHCV) Scheme since 2009, General Out-Patient Clinic PPP Scheme (GOPC PPP) since 2014, and Colorectal Cancer Screening Programme since 2016. Together these subsidised programmes accounted for some $3 billion government fixed expenditure on PHC in 2019/20.

The Department of Health

33. DH is the Government's health adviser and agency to execute healthcare policies and statutory functions. It safeguards the community's health through a range of promotive, preventive, curative and rehabilitative services. Healthcare services are being delivered using a life course approach through DH's various areas of work with emphasis on preventive care. The key healthcare functions of DH are in **Table 2.1**.

Table 2.1
DH's Key Healthcare Functions

HealthPromotion	
Health Promotion Branch; Oral Health Education Division; Special Preventive Programme	• Health promotional activities and programmes that target both the population at large and also specific groups
Disease Prevention and Control	
Centre for Health Protection (Communicable Disease Branch; Non-communicable Disease Branch; Emergency Response and Programme Management Branch; Public Health Services Branch; Infection Control Branch; Public Health Laboratory Services Branch; Specialised Services Branch; Health Administration and Planning Office)	• Prevention and control of both communicable and non-communicable diseases (NCDs) are executed through surveillance, outbreak management, health promotion, risk communication, emergency preparedness and contingency planning, infection control, laboratory services, specialised treatment and care services, training and research (including surveys) • Disease prevention programmes, including vaccination programmes and cancer screening programmes
Clinical Genetic Service; Family Health Service; Student Health Service; Elderly Health Branch; School Dental Care Service	• Health promotion and provision of preventive care to individuals of specific age groups and/or carers • Immunisation, screening of congenital diseases, growth monitoring and developmental assessment, and health assessment for population groups including children, primary and secondary school students, women, elderly; and dental check-up for primary school children • Ante/postnatal care and family planning service for child bearing age women, cervical screening services, diagnostic and counselling for genetic diseases, primary healthcare services including chronic and episodic disease management for the elderly • Implementation of the Elderly Health Care Voucher Scheme
Tobacco and Alcohol Control Office	• Promotion of a tobacco-free culture and co-ordination of smoking cessation services
Curative Care and Rehabilitation	
Child Assessment Service	• Assessment and rehabilitation plan formulation to enable children to overcome developmental problems
Social Hygiene Service	• Medical care and health promotion for the prevention and management of sexually transmitted diseases and skin diseases
Special Preventive Programme	• Medical care and health promotion for the prevention and management of sexually transmitted diseases, viral hepatitis and HIV/AIDS
Tuberculosis and Chest Service	• Medical care and health promotion for the prevention and management of tuberculosis and respiratory diseases

34. Apart from direct services, DH also runs disease prevention programmes by way of PPP, including programmes for vaccination (such as the Government Vaccination Programme and the Residential Care Home Vaccination Programme that provide seasonal influenza vaccination and pneumococcal vaccination for elderly living in the community and residential care homes), cancer screening (such as colorectal cancer screening programmes) and smoking cessation.

Hospital Authority

35. HA, established under the Hospital Authority Ordinance (Cap. 113) in 1990, provides public hospital and related services. It offers medical treatment and rehabilitation services through hospitals, SOPCs, GOPCs, outreach services and Chinese Medicine Clinics cum Training and Research Centres (CMCTRs). They are organised into seven clusters that altogether serve the whole city. In parallel, HA has provided a range of PHC services, including the general out-patient services, multi-disciplinary services, chronic disease management programmes including risk assessment and management programme (RAMP), nurse and allied health clinics (NAHCs) and community nursing services (CNS).

36. In line with the Government's healthcare reform proposals, since 2008, HA has launched a range of PPP programmes with designated one-off funding from the Government. In 2016, a dedicated endowment fund, the HA PPP Fund, was set up to allow HA to generate investment returns for regularising and enhancing ongoing clinical PPP programmes, as well as for developing new clinical PPP programmes. Among the existing PPP programmes, several of them are PHC- focused, most notably the GOPC PPP launched in 2014 and patient empowerment programme (PEP) launched in 2010. It provides patients with HT and/or DM but in stable clinical conditions a choice to receive subsidised treatment provided by private doctors.

37. A brief summary of the key PHC functions of HA is in Table 2.2.

Table 2.2 HA's Key PHC Functions

Multi-disciplinary Risk Assessment and Management Programme (RAMP)
• Multi-disciplinary teams of healthcare professionals are set up at selected GOPCs of HA in all clusters to provide structured risk assessment and targeted interventions for patients with DM and HT, so that they can receive appropriate preventive and follow-up care.
Nurse and Allied Health Clinics (NAHCs)
• NAHC comprising of nurses and allied health professionals have been established in selected GOPCs in all clusters to provide more focused care for high-risk chronic disease patients, targeting those who require specific healthcare services and those with health problems or complications. These services include fall prevention, handling of chronic respiratory problems, wound care, continence care and drug compliance.
Patient Empowerment Programme (PEP)
• A PEP was implemented in all HA clusters in collaboration with NGOs. They aimed to improve chronic disease patients' knowledge of their diseases and enhance their self-management skills.
• A multi-disciplinary team from HA developed appropriate teaching materials and aided for common chronic diseases (for example, HT, DM, etc.), and provided training for frontline staff of the participating NGOs organising the PEP.
• With gradual setting up of DHCs/DHC Expresses in different districts, collaboration between DHCs/DHC Expresses and HA has been put in place for patients with HT and/or DM under the care of HA for patient empowerment and better support in the community.
General Out-patient Clinics (GOPCs)
• The general out-patient services provided by HA are open to all population groups with major service users being the elderly, the low-income and the chronically ill patients. Patients under the care of GOPCs comprise two major categories: chronic disease patients, such as patients with DM or HT; and episodic disease patients with relatively mild symptoms.
• HA expanded the service capacity in (GOPCs) by increasing the quota over the years and launching the GOPC PPP in 2014. GOPC PPP provides patients with HT and/or DM (with or without hyperlipidemia) but in a stable clinical condition a choice to receive subsidised treatment provided by private doctors.

Community Health Centres (CHCs)
• To tie in with the government's PHC development strategy, HA has been actively planning for the development of CHCs in various districts. With an aim to provide integrated and comprehensive PHC services, the CHCs provide medical consultation, multi-disciplinary services to complement doctors' management and control disease deterioration, as well as patient empowerment to encourage self-care.
Community Nursing Services (CNS)
• CNS provides nursing care and treatment for patients in their own homes. Through home visits, Community Nurses administer proper nursing care to patients and, at the same time, imbue patients and their families with knowledge on health promotion and disease prevention. The ultimate goal of CNS is to provide continuous care for patients who have been discharged from hospitals and allow them to recover in their own home environment.
Chinese Medicine Clinics cum Training and Research Centres (CMCTRs)
• CMCTRs, with one established in each district, operate on a tripartite collaboration model involving HA, an NGO and a university. The NGOs are responsible for the running and day-to-day operation of the CMCTRs. In addition to non-subsidised out-patient Chinese medicine services, training and research functions, the CMCTRs have been providing Government-subsidised Chinese medicine out-patient services since March 2020.

Social Services Sector

38. With the combined effect of an ageing population and increasing longevity, the Government has been introducing various measures on elderly services mainly under the Labour and Welfare Bureau (LWB) and administered by the Social Welfare Department (SWD) with a view to promoting "active ageing" while taking care of the service needs of frail elderly persons. In terms of community-based services, SWD oversees a number of community support services, such as District Elderly Community Centres (DECCs) and Neighbourhood Elderly Centres (NECs). Although the purpose of these centres are not primarily health-focused, the medical and social need of elderly is often intertwined. For instance, DECCs and NECs invite the visiting health teams (VHTs) of the Elderly Health Service of DH in organising health education talks on different topics, such as disease prevention, nutrition and balanced diet, and organise group activities on physical exercises which aim at promoting a healthy lifestyle.

THE CHALLENGES

39. Respective Government bodies overseeing health and social policies (i.e. HA, DH and SWD) have been working in tandem to offer PHC services, via PPP as appropriate, while performing their respective functions. They have been complementing and facilitating implementation of the Government's public health policies through collaboration and service referrals at different levels to serve the public. Different units at DH that provide PHC services, such as Maternal and Child Health Centres (MCHCs), Woman Health Centres (WHCs), Student Health Service Centres and Elderly Health Centres (EHCs), refer their patients to the SOPCs of HA for follow-up treatment according to their needs. HA also supports the programmes of DH (e.g. the Government Vaccination Programme) where appropriate. Similarly, the SWD units which provide some PHC services, such as DECCs and NECs will also take on cases referred by HA for community support, such as those elderly patients who have been discharged from hospitals and carry a higher risk of unplanned re-admission.

40. Nonetheless, the current PHC system is still fragmented with a lack of overall strategic planning and co-ordination on service development. We recognise the need for synchronising and consolidating various PHC services, including those introduced and operated by different parties over time. **There is much room for further integration and streamlining on both horizontally among PHC service providers and vertically between primary and secondary/tertiary healthcare sector.**

OUR AIM

41. The Government recognises the need to establish a more systematic and coherent platform to incentivise the community to manage their own health, promote awareness of the importance of PHC services and improve service accessibility. For the sustainable development of the PHC system in Hong Kong, we see the need to strengthen planning and co-ordination of resources. We also need to improve service efficiency and effectiveness by leveraging on both public and private PHC services resources.

42. Besides, with the reaffirmed positioning of Chinese medicine (CM) in the development of the healthcare system in Hong Kong in the 2018 Policy Address, a combination of defined Government-subsidized CM services has been provided/are to be provided at the level of primary, secondary and tertiary healthcare. CM, which emphasizes a holistic approach to understand life and provide holistic care of patient, together with the prime concept of preventive treatment of disease (including elements of prevention, care and health maintenance, etc.), should play a more significant role in the PHC system, leveraging on its strategic advantage and expertise. Multi-disciplinary collaboration should be explored to achieve better synergy effect.

43. With the continuous development of DHCs across the territory, **we aim to shift from our current PHC delivery model into an integrated and co-ordinated district-based family-centric community health system, with accessible referral channels and clear patient pathway that connect service providers across the healthcare continuum.**

44. In view of the above, we propose the following –

RECOMMENDATION 2.1
DEVELOP A DISTRICT-BASED FAMILY-CENTRIC COMMUNITY HEALTH SYSTEM

45. To strengthen collaboration between the health and social care sectors and public-private partnership in a district setting, with a view to enhancing public awareness in disease prevention and self-health management, offering greater support for patients with chronic diseases, and relieving the pressure on specialist and hospital services, the Government is committed to enhancing district-based PHC services by setting up DHCs throughout the territory progressively since 2019. Through district-based services, public-private partnership and medical-social collaboration, the DHC is a brand new service model and will be a key component of the public healthcare system. The establishment of DHCs is a key step in a bid to shift the emphasis of the present healthcare system and people's mindset from treatment-oriented to prevention-oriented. A summary of the existing service model of DHC is at **Table 2.3**.

46. With the establishment of DHCs across the territory, DHCs will progressively strengthen their role as the co-ordinator of community PHC services and case manager to support PHC 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 PHC and social service providers.

Table 2.3
Existing Service Model of District Health Centres

	Existing Service Model of District Health Centres (DHC)
Role	• Anchor of a new district-based healthcare model which leverages on public-private partnership and medical-social collaboration. It provides better primary healthcare service and co-ordination in the community • A service network developed through partnership with organisations and healthcare personnels on the district level to support PHC doctors and enhance service accessibility and co-ordination
Health Priorities	• The top four prevalent chronic diseases and health conditions in Hong Kong: (a) obesity and overweight (b) hypertension (c) diabetes mellitus (d) musculoskeletal diseases
Service Model	• One DHC in each district operated by a non-government entity • Each DHC Operator is required to operate a Core Centre and Satellite Centres, employ a Core Team and build a DHC Service Providers Network • It collaborates with non-government organisations in the community as partners to enhance the local support network
DHC Core Team and Network Service Providers	• A Core Team of staff is employed by the DHC Operator which consists of an executive director, chief care co-ordinator, care co-ordinators, dietitian, pharmacist, physiotherapist (PT), occupational therapist (OT), social worker and administration, information technology and finance personnel • The DHC Operator is required to establish a district service network consisting of doctors, Chinese medicine practitioners and allied health professionals (such as PT, OT, optometrist, dietitian) within or adjacent to the district through service agreements. These network service providers will receive referrals from the DHC for providing subsidised services to members, or make referrals to the DHC
Eligibility for DHC Services	• Individual who is a holder of the Hong Kong Identity Card • Living or working in the district • Agree to enroll in the Electronic Health Record Sharing System (eHealth) and to share information on eHealth for relevant service needs
Service Areas	• Primary prevention: Health promotion, education and resource hub • Secondary prevention: Health risk factors assessment and chronic disease screening • Tertiary prevention: Chronic disease management and community rehabilitation
Government Financial Subsidy	• Primary prevention services provided by the Core Team, including nursing, pharmacy and social work consultation service, and health promotion and activities are **free of charge** • The Government provides **subsidies** to patients for medical consultation, medical laboratory tests, individualised allied health services and Chinese medicine acupuncture and acupressure treatment by network service providers in the community • **Co-payment** for part of the service costs are required to strengthen the ownership of individuals' own health management

Family Doctor for All

47. Family doctors, as the first point of contact for individuals and families in the healthcare process, are the main provider of primary care, which is the first level of care in the whole healthcare system. They provide comprehensive, continuing, whole-person, co-ordinated and preventive care to individuals and their families to ensure their physical, psychological and social well-being.

48. The Government has been promoting the "family doctor for all" concept since 2005 after the consultation document "Building a Healthy Tomorrow", which emphasised on the provision of preventive care and continuity of care through family doctor and family doctor as patient's first point of contact. More detailed proposals were

put forward in the later consultation documents "Your Health, Your Life Consultation Document on Healthcare Reform" in 2008 and "Our Partner for Better Health - Primary Care Development in Hong Kong : Strategy Document" in 2010, including incentivising individuals to undertake preventive care through private family doctors, and developing a Primary Care Directory with appropriate training and qualification requirements for the register of family doctors so as to promote the family doctor concept and continuous enhancement of quality of primary care.

49. To curb the burden of non-communicable diseases (NCDs), the Government has launched "Towards 2025: Strategy and Action Plan to Prevent and Control Non-communicable Diseases in Hong Kong" (SAP) in 2018. One of the initiatives in the SAP is to strengthen the health system at all levels, in particular comprehensive primary care for prevention, early detection and management of NCDs based on the family doctor model. A summary of the Government's advocation of family doctor concept is at **Table 2.4**.

50. Going forward, the "Family Doctor for All" concept will remain as a fundamental guiding principle for the development of various primary healthcare policy under the Blueprint. The Government will require all family doctors and healthcare professionals participating in PHC service provision to be enlisted on the PCR and commit to using the RFs, including those enrolling in government-subsidised programmes such as the EHCV Scheme and CDCC Scheme, in order to provide quality assurance to users of PHC services, establish the "gold standard" for PHC service providers, and provide incentives for PHC professionals to adopt best practices and participate in co-ordinated care (see **Recommendation 3.2**). For the public, we will also propose registering with a family doctor as one of the pre-requisites for joining the CDCC and EHCV Scheme 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 care due to the sustained nature of chronic diseases (see **Recommendation 2.2; 4.1 and 4.2**). The ultimate goal is to have all members of the public to each be paired with a family doctor of their own, along with their family members, who would act as their personal health manager for development of personalised care plan with the support and assistance of DHCs.

Table 2.4 Family Doctor Concept Advocated by the Government

Family Doctor
• Family doctor is the major primary care service provider who provides comprehensive, family-centric, continuing, preventive and co-ordinated care to you and your family members, taking care of the health of you and your family members. • Apart from treating and caring of acute and chronic diseases, a family doctor also plays a crucial role in supporting you continuously in prevention and self-management of diseases. • A family doctor has good understanding of your health conditions and needs. He can provide you the most suitable care and professional advice in promoting your health.
Family Doctor and Children
• Being your health partner, a family doctor provides comprehensive and continuing care to you and your family, including your children. Your family doctor knows your children well and can provide the most suitable preventive care as well as professional advice for any concerns on the health or development of your children.
Family Doctor and Elders
• Being a health partner of you and your family, a family doctor provides continuing care and anticipates your changing needs during different stages of life. • Growing old is one of the normal stages of life. Ageing brings about physical, psychological and cognitive changes or decline. Yet, some changes are not normal and may be early symptoms of underlying diseases. Should there be any suspicion of abnormal body changes, it is wise to seek advice from your family doctor who offers assessment and treatment tailored to your needs. • Furthermore, a family doctor also helps you to prevent diseases by various means such as vaccination and evidence-based screening.

DHC's Support to Family Doctors

51. As a hub with multiple access points, DHCs would support PHC family doctors by acting as care co-ordinators, accepting and making referrals to primary care providers in the community for consultation, co-ordinate, synergise and maximise community health services, as well as build and strengthen the social support to sustain the health initiative on the individual and community levels through medical-social collaboration. DHCs are set to complement but not compete with PHC doctors or similar service providers on first contact medical care. DHC are equipped with the necessary supportive healthcare services and are set to act as the district co-ordinators and resource hubs for territory-wide PHC services. On the other hand, pilot PHC initiatives could also be implemented via the district-based community health system to provide evidence-based results for the Government in planning long-term territory-wide PHC policies.

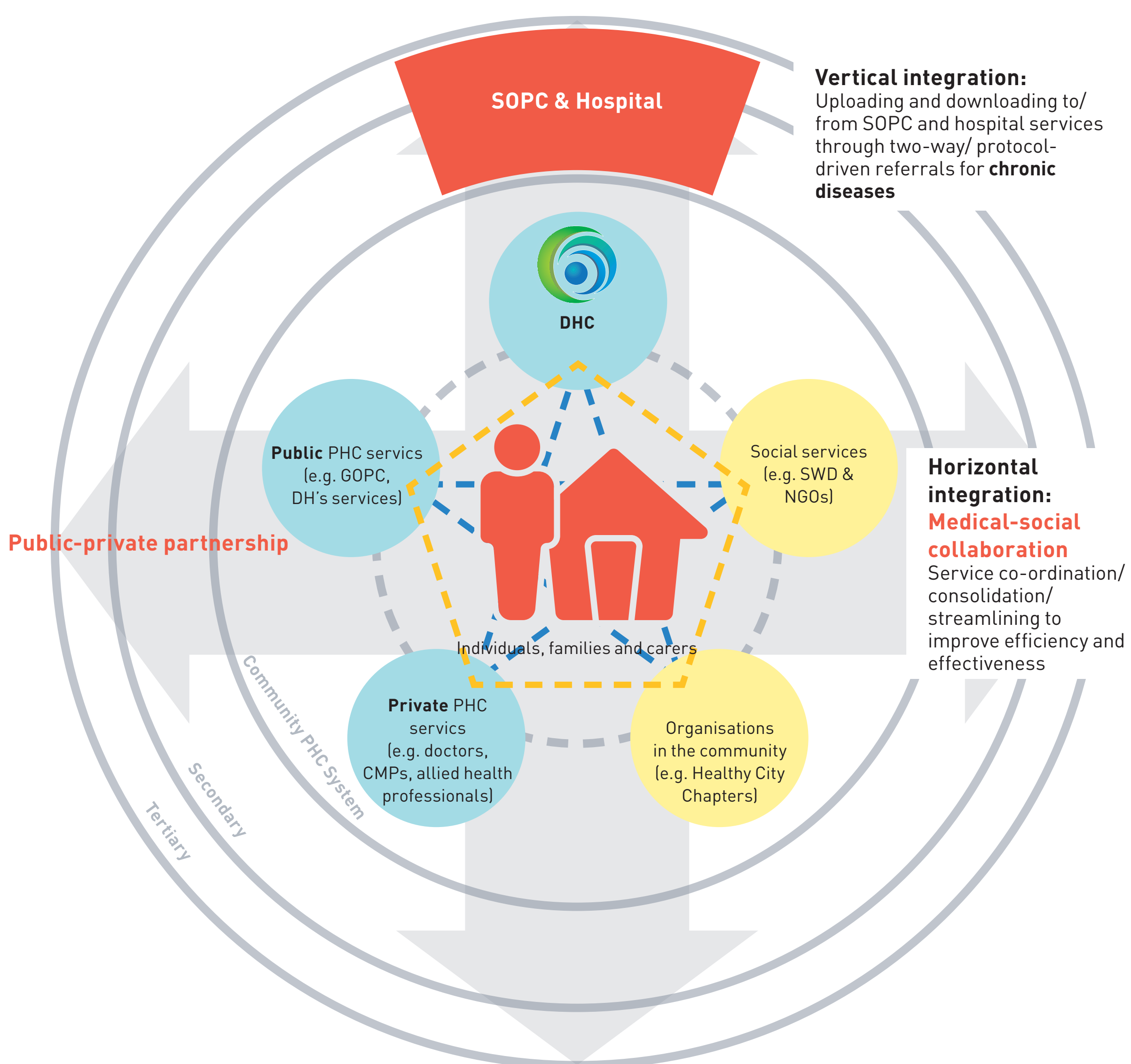
52. Through eHealth, DHCs would collect and analyse information related to the district's population health for Government's healthcare service planning, strategic purchasing, and monitoring and evaluating the performance of care providers (see **Chapter 6**). DHCs would also serve as a district health resource hub to collect information on healthcare resources available in the district. Such information can be used by the general public and facilitate individualised care where necessary.

53. DHCs are key channels on the community level which complement and deliver the Government's healthcare policies and initiatives. For example, in response to the COVID-19 pandemic, the DHCs and DHC Expresses have been performing their frontline roles in different districts by actively taking part in anti-epidemic work on the district level. The epidemic prevention and control work carried out by DHCs on the district level includes providing COVID-19 vaccination service, distributing anti-epidemic supplies and rapid testing kits, disseminating COVID-19-related health information, organising anti-epidemic education activities, providing hotline support service to the public, and providing rehabilitation support for COVID-19 recoverees, etc. These functions are essential in contributing to the Government's preparedness and response during the epidemic as they provide accessible and efficient information and resource dissemination on the district level.

54. Riding on the above development, we propose to further develop a district-based family-centric community health system based on the DHC model with an emphasis on horizontal integration of district-based PHC services through service co-ordination, public-private partnership and medical-social collaboration, as well as vertical integration or interfacing with secondary and tertiary care services through protocol-driven care pathway for specified chronic diseases supported by well-trained primary care medical practitioners playing the role as family doctors in order to further strengthen the concept of "Family Doctor for All" especially in matters concerning chronic disease management (see also **Recommendation 2.2** and **Chapter 3**).

55. **The PHC sector is envisaged to be integrated and co-ordinated to serve as a gate-keeper to the public secondary healthcare system.** It aims to improve service efficiency and effectiveness, as well as helping patients navigate each level of the healthcare system efficiently. A conceptual model of the district-based community health system is in **Figure 2.1**.

Figure 2.1:
Vertical and horizontal integration of healthcare services in a district-based community health system



Consolidation of Public Primary Healthcare Services

56. As discussed above, there appears to be service and resource overlap within the public healthcare sector. Also, there is room for various PHC services to be consolidated. As the service model and scale of DHC continue to grow and solidify, we see the need to drive the consolidation of public PHC in DH and HA in order to reduce service duplication and enhance resource efficiencies.

57. Among a wide range of clinical services provided by DH, while most of them carry significant public health functions, a few of them share similar PHC objectives. As the district-based community health system evolves, **the Government proposes to progressively migrate PHC services under DH to the district-based community health system, especially those with room for more efficient delivery on the district level through an alternative approach, with a view to facilitating provision of integrated PHC services within the district-based community health system and reducing service duplication.** Taking into account the level of synergy and impact of service transition, a phase by phase approach is recommended as highlighted in **Table 2.5**.

Table 2.5 Migration of direct services from DH

Phase I (Short Term)
• Elderly Health Centres
• Woman Health Centres
• PPP Programmes
Phase II (Medium Term)
• Student Health Service Centres
• Maternal and Child Health Centres – Family Planning and Cervical Cancer Services

Elderly Health Centres

58. Since 1998, DH has established 18 EHCs in each of the districts to address the multiple health needs of the elderly by providing to them integrated PHC services. Enrolled members aged 65 and over are provided with various healthcare services, including health assessment, counselling, health education and curative treatment, delivered by a multi-disciplinary team. In response to the COVID-19 pandemic, EHCs disseminated COVID-19-related health information, provided talks as well as offered COVID-19 vaccination service to elderly. They also participated in distribution of anti-epidemic supplies and rapid testing kits. With the increase of an ageing population, EHCs face the challenge of limited service quota to a large unmet demand.

59. To achieve service synergy, we have devised a collaboration model for the EHC and DHC within the same district with the first DHC in Kwai Tsing, which commenced operation in September 2019, as a start. The EHCs have been actively collaborating with DHCs to implement joint protocols for cross-referral of clients.

60. As EHC and DHC services become increasingly complementary to each other, we shall begin to migrate EHC services to DHCs with a step by step approach. Upon migration, EHC members shall continue to receive health assessments and health education at DHCs with a stepped up protocol catering for the elderly. Meanwhile, medical needs arising from their chronic and elderly conditions shall be cared for at GOPCs.

Woman Health Centres

61. Currently, DH's three WHCs provide PHC services to women and empower women to make the life choices that are conducive to their health. Women may seek appropriate healthcare and/or social services at the centres when necessary. They provide accurate and updated information on women's health issues as well as the access to relevant community resources.

62. In 2021, the Breast Cancer Screening Pilot Programme was rolled out to provide breast cancer screening for eligible women. Under the programme, WHC members will receive mammography screening at a subsidised rate upon indication.

63. Similar to the EHC, WHC and DHC services are increasingly complementary to each other. With the conclusion of the Breast Cancer Screening Pilot Programme, we shall commence to migrate WHC services to DHCs and also private healthcare providers through PPP as appropriate. After service migration, stepped up health assessment tools will be used by DHCs to cater for specific women's health needs. DHCs shall assume the role of provision of health assessment, education and individual counselling for women.

64. In the longer term, the Government will recommend alternative approaches on healthcare service delivery at those direct PHC service centres. The aim is to allow for more cost-effective provision of healthcare services on top of current service delivery model within the district-based community health system and at the same time maximise overall population health beyond the existing direct service delivery mode (see **Chapter 3 and 4**).

Primary healthcare functions of Hospital Authority

65. HA Patient Programmes, covering HA patients, aim to achieve the Government's objective of building an integrated healthcare system with respect to HA services. While its focus is mainly on secondary and tertiary care, it has also implemented a

number of PHC-related services (including some strategic purchasing programmes). **Alongside the evolvement of the district-based community health system,** subject to the HHB's policy consideration and Primary Healthcare Commission's oversight, these programmes could be expanded, discontinued or modified to suit the latest policy / programme objectives. For example, patient empowerment, community support, maintenance rehabilitation and nursing services in primary care currently provided by HA are considered suitable for collaboration with DHCs. The Government will continue to work with HA on the integration of different services to provide comprehensive patient care, to optimally allocate resources and to avoid duplication.

66. One of the most important PHC functions of HA rests with its GOPCs. Whilst HA will continue to oversee the GOPCs as part and parcel of a complete patient journey and for the performance of a safety net and public health function, the proposed positioning of GOPCs in the management of chronic diseases will be further discussed in **Recommendation 2.3**. The establishment of the primary-secondary healthcare pathway, in particular for targeted chronic diseases, will be discussed in **Chapter 3 - Recommendations 3.2 and 3.3**.

67. As regards CM services, HA has also been actively promoting the collaboration between the CMCTRs and DHCs. For example, during the "San Jiu Tian" Period in December 2021, CMCTRs collaborated with three DHCs/DHC Express (including Kwai Tsing DHC, Sham Shui Po DHC and Sai Kung DHC Express) to provide Tian Jiu services on a trial basis and organise CM thematic seminars, which were well received by the members of the public. **To fully unleash the potential of CM in PHC settings and further promote the development of CM in Hong Kong, the Government will continue to enhance PHC services provided by the CMCTRs through service planning, explore the positioning of CMCTRs within the PHC system, and further the collaboration between CMCTRs and other PHC stakeholders.**

Medical-social collaboration

68. To enable the concept of whole-person care, we need to strengthen the medical-social collaboration aspect in the district-based community health system. The social service sector plays an important role in the district-based community health system by providing an effective and complementary social support network. **The district-based community health system should therefore support the collaboration between healthcare and social services.** While patients receive medical care in their districts, enhancing the capacity of patients' carers and family is also necessary. They help to manage patients' health (including both physical and mental), make appropriate healthcare decisions and respond to emergencies.

69. Upon the establishment of the district-based community health system, co-operation between the community support provided by DECCs/NECs and healthcare support provided by public PHC services will be enhanced. This will facilitate medical-social collaboration, family-centric and co-ordinated care, particularly to hidden and vulnerable elderly persons and their carers.

RECOMMENDATION 2.2

Enhance chronic disease management through the private primary healthcare sector

70. As discussed in **Chapter 1**, to achieve healthcare system sustainability, a shift in the emphasis of the present healthcare system to a prevention-oriented healthcare model with a focus on chronic disease management is important. Due to its prevalence, burden and costliness, intervening chronic diseases at an early stage is important. Through the district-based community health system, the Government aims to incentivise citizens to prevent the development of chronic diseases. The Government also hopes to facilitate early identification and provide timely intervention of designated chronic diseases at the community level with the assistance of healthcare service providers in their localities. For those individuals diagnosed with chronic diseases, we strive to prevent and manage associated complications to reduce need for hospitalisation.

71. As discussed in paragraph 36, the GOPC PPP was launched in 2014 in phases with an aim to help relieve the demand for HA's general out-patient services by leveraging on the resources of the private sector. Under the GOPC PPP, clinically stable patients with HT and/or DM originally being taken care of by GOPCs would be invited for voluntary participation in the Programme and opt for care from a private doctor of their choice to follow up on their chronic diseases. In addition to relieving the pressure off the public healthcare system, the Programme also aims to cultivate a long-term doctor-patient relationship between the patient and his/her family doctor in order to achieve the objectives of continuous and holistic primary care. To date, over 600 private medical practitioners have participated in the GOPC PPP Programme, covering all 18 districts of Hong Kong. Service provisions, participating service providers and expenditure of GOPC PPP over the years are listed in **Table 2.6**.

Table 2.6
Service statistics of GOPC PPP

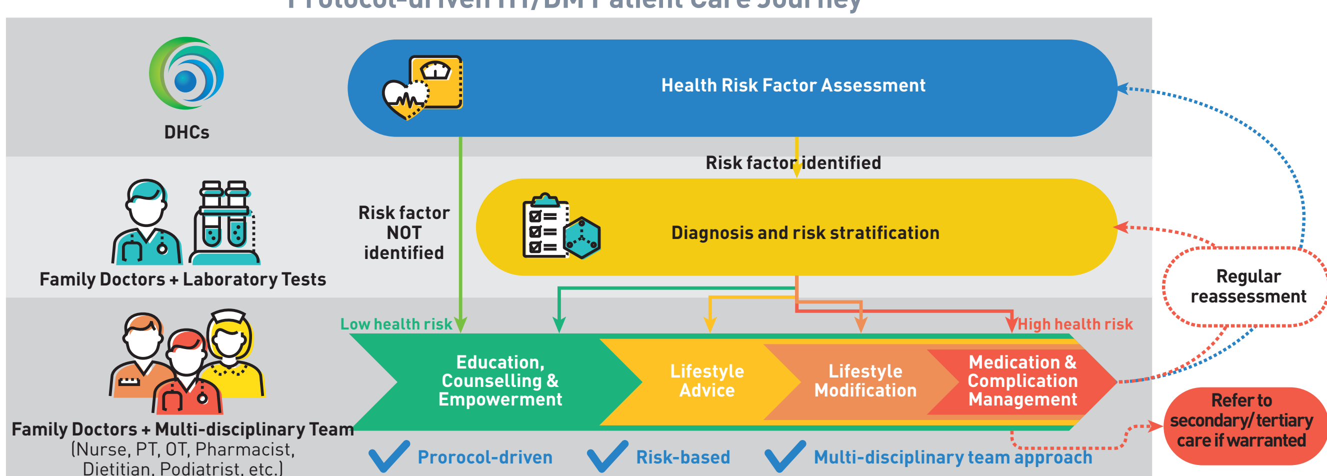
	2019-20	2020-21	2021-22	2022-23
No. of Participating Patients	35 815	39 700	41 804	49 280 *(Planned Provision)*
No. of Participating Service Providers	439	575	604 *(as at end-2021)*	617 *(as at end-Aug 2022)*
Expenditure ($ million)	82.5	89.4	97.7	130.8 *(Estimated Financial Requirements)*

72. Riding on the existing GOPC PPP, HA has introduced the Co-care Service Model in late 2021 by gradually extending the patient invitation pool to patients of HA SOPCs. In consultation with HA's clinical expertise, the Co-care Service Model is being piloted in three specialties viz. Medicine (MED), Orthopaedics & Traumatology (O&T) and Psychiatry (PSY). Eligible patients who had been following up at MED, O&T and PSY SOPCs were invited by batches to participate in the programme under the Co-care Service Model.

73. On the other hand, as one of the existing DHC services, DHCs would proactively identify people with high risk of HT and DM through basic health risk factor assessments for further diagnosis by network medical practitioners from the private sector. Those with confirmed diagnosis would be invited to join the DHCs' protocol-driven structured HT/DM management programmes. Under the DHC HT/DM management programmes, these cases would be managed by a primary care doctor-led multi-disciplinary team consisting of nurses, pharmacists, allied health professionals, social workers and other workers in healthcare and social services under the care co-ordination of DHC. Subsidised individual allied health services are offered under the DHC HT/DM management programmes.

74. The existing DHC chronic disease management protocol has been developed with reference to the relevant Reference Frameworks (RFs) in primary care settings issued by the Government and the Risk Assessment and Management Programme (RAMP) introduced in HA for HT and DM patients, which includes complication screening, interventions and education from a multi-disciplinary healthcare team, proven to be cost-effective. To further incentivise DHC members to receive holistic care in the community, we proposed in the 2020 Policy Address to implement a Pilot Programme for chronic disease management by providing subsidised medical consultation by private medical practitioners for DHC members who are newly diagnosed with HT or DM, in addition to the prevailing screening and allied health services which are already subsidised for DHCs members.

Figure 2.2:
Protocol-driven HT/DM Patient Care Journey



75. **We propose to introduce a "Chronic Disease Co-Care Scheme" (CDCC Scheme)** to provide targeted subsidy for the public to conduct diagnosis and management of target chronic diseases (especially HT and DM) in the private healthcare sector through "family doctor for all" and a multi-disciplinary public-private partnership model. Through the CDCC Scheme, we hope to facilitate early identification and timely intervention of chronic diseases so as to reduce the demand for specialised and hospital services. It also provides an additional choice of services for chronic disease patients outside of the public healthcare system. While chronic diseases are considered as an appropriate disease-based intervention point for the CDCC Scheme due to their high prevalence, treatment efficiency and financial burden if otherwise left untreated, the introduction of the CDCC Scheme is also expected 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 care due to the sustained nature of chronic diseases.

76. Based on a co-payment system, chronic disease patients with higher affordability are envisaged to obtain the required PHC services through the network of participating PHC professionals of the CDCC Scheme of their choice. Service providers for the management model are subject to the Government's monitoring and quality assurance, and shall follow the standardised care protocol and referral mechanism for management of chronic diseases **(See Chapter 3- Recommendation 3.2 and 3.3)**.

77. As announced in the 2022 Policy Address, the CDCC Scheme shall be implemented in a three-year pilot basis with a view to testing out the model. The Government shall invest into the CDCC Scheme in order to encourage all citizens to benefit from early intervention and management of these targeted chronic diseases. The enhancement of PPP in the primary care setting would contribute to the quality and efficiency of publicly-funded primary care services and alleviate pressure on the public healthcare system. The subsidisation model will be discussed at **Chapter 4 - Recommendation 4.1**.

RECOMMENDATION 2.3

Review the position of the public general out-patient services

78. 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.

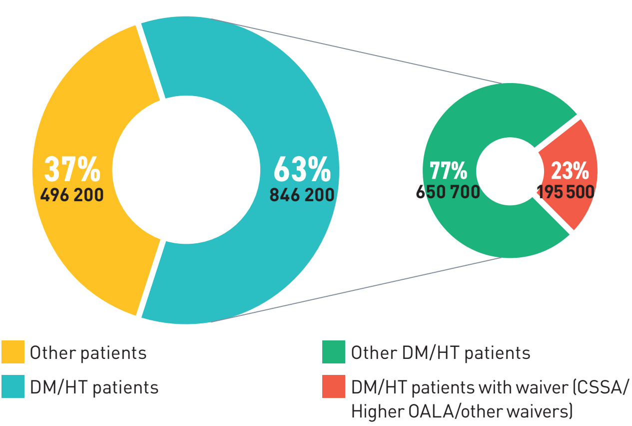
79. HA has been offering PHC services through 73 GOPCs (including three Community Health Centres (CHCs)) with major service users being the elderly, the low-income group and the chronically ill. Patients under the care of GOPCs can be broadly divided into two main categories, namely chronic disease patients with stable conditions (e.g. DM and HT) and episodic disease patients with relatively mild symptoms (e.g. influenza, colds). In 2019/20, excluding GOPC patients with civil service or HA staff benefits, 63% of GOPCs' patients were DM/HT patients (846 200 patients), among which 23% (195 500 patients) were recipients of Comprehensive Social Security Assistance, Higher Old Age Living Allowance or other fee waivers. The remaining 37% were non-DM/HT patients (see **Figure 2.3**).

80. GOPCs also assume a major role in the community during COVID-19. Since July 2020, GOPCs have been supporting the Government in distributing specimen collection packs and collecting specimens, and vending machines were installed at selected GOPCs to assist individuals in need to obtain specimen collection packs. HA has also been providing COVID-19 vaccination services to the general public through different channels (including provision of vaccination services at selected GOPCs since February 2021). During the fifth wave, HA had activated a maximum of 23 GOPCs into designated clinics for COVID 19 confirmed cases to help provide treatment and prescribe COVID-19 oral drugs for confirmed patients in the community presenting with relatively mild symptoms of infection, especially high risk patients. Starting from July 2022, HA also provides tele-consultation service through designated clinics to facilitate suitable

COVID-19 patients to receive medical consultation and medication delivery service in the community. The designated clinics and tele-consultation service provided timely and appropriate medical support to patients at the community level.

81. The above illustrates the importance of GOPCs as a publicly-run PHC facility at the community level. Nonetheless, as discussed in paragraph 66, whilst the GOPCs would continue to be provided by HA as part and parcel of a complete patient journey for the performance of safety net and public health function, with the introduction of the above CDCC Scheme which aims to better utilise private PHC resources, we see the need to reposition GOPCs 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).** In 2019/20, among GOPCs' HT/DM patients (excluding patients with civil service or HA staff benefits), about 23% were fee-waiving patients (i.e. either recipients of Comprehensive Social Security Assistance or Higher Old Age Living Allowance or other fee waivers. As for chronic disease patients not among the above target group, which account for about 77% of the current GOPC chronic disease patients with DM and/or HT (excluding patients with civil service or HA staff benefits), instead of using public PHC services, they may also choose to seek private PHC services and join the CDCC Scheme for chronic disease care.

Figure 2.3:
Target users of GOPC's service



*The above figures exclude service users with civil service benefit/HA benefit

82. Through an appropriate referral mechanism, it is envisaged that some of the chronic disease patients currently under GOPCs' care could be diverted to the private healthcare sector through the abovementioned CDCC Scheme. The freed up resources could allow GOPCs to provide better care for their target chronic disease patients through wider utilisation of RAMP. The protocol-driven referrals will be further discussed in **Chapter 3-Recommendation 3.3**.

83. With the territory-wide rollout of the CDCC Scheme and the repositioning of GOPCs, the existing GOPC PPP and Co-care Service Model will be reviewed with a view to streamlining service focus to ensure the cost-effective use of public funds and to explore the feasibility of introducing other PPP programmes for strategic purchasing of PHC services from the private sector (see **Chapter 4**).

CHAPTER 2 - DEVELOP A COMMUNITY-BASED PRIMARY HEALTHCARE SYSTEM: ACTION PLAN					
	Action		Short	Medium	Long
2.1	**DHCs**	• To set up 7 DHCs and 11 DHC Expresses			
		• To set up 18 DHCs across the territory			
		• To review the DHC service model			
	Migration of PHC Services	• To migrate public PHC services from DH			
		• To migrate PHC services (e.g. patient empowerment, community support, etc.) from HA			
		• To enhance collaboration between DHC and DECCs/NECs			
2.2	**"Chronic Disease Co-Care Scheme" (CDCC Scheme)**	• To review the Sham Shui Po DHC Pilot Programme for chronic disease management upon completion of pilot programme			
		• Upon review of the Pilot Scheme, to gradually expand the CDCC Scheme to all HT and DM patients in Hong Kong			
		• To review the CDCC Scheme and explore possible expansion			
2.3	**Review of-GOPCs' positioning**	• To divert GOPCs' non-target group patients with HT and/or DM to receive subsidised treatment provided by private sector via CDCC Scheme			

CHAPTER

STRENGTHEN PRIMARY HEALTHCARE GOVERNANCE

While the public healthcare system has a strong and formal accountability system and a system is in place to hold private healthcare service providers accountable to their customers, it is necessary that we maintain the standard and quality control of the service sector as a whole. In particular, there is a need for **standardisation and assurance of the quality of PHC services across public and private providers to ensure that the whole PHC system is driving towards the Government's overall PHC policy and delivering the intended health outcomes**. It is also necessary to set up an **overarching governance structure to steer and enhance cross-sectoral and inter-organisational co-ordination among PHC services** provided by public and private healthcare service providers at the community level. Enhancement of performance monitoring tools, and improvement on standardisation and transparency in the services across the public sector and the private sector, where PHC services take place, are some of the key issues to be addressed. With the participation of well-managed private PHC providers in the PHC system, we envisage to see improvements in the quality of health for individuals and the population as a whole.

84. Health system governance is the cornerstone for creating a desirable and balanced healthcare system for delivering the intended health outcomes in the healthcare system. According to the WHO, leadership and governance in building a health system is essential in ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability [18].

Healthcare Governance in Hong Kong

85. Health Bureau (HHB) is the Government Bureau overseeing overall health system policies and responsible for the governance of Hong Kong's healthcare system, oversight of public health and access to ensure care for all citizens. It has assumed the role of the overall commissioner of public health services through the annual budgetary and resource allocation exercise. The Government has been monitoring the operation and utilisation of resources of HA and DH through various channels.

The Department of Health

86. Established in 1989 upon the re-organisation of the former Medical and Health Department, DH is the Government's health adviser which performs public health functions including health promotion, disease prevention as well as regulation of drugs and healthcare facilities. With the changing health needs of the community brought about by challenges such as changes in trends of diseases, emerging and re-emerging infections, ageing population,

and advances in IT and medical technology, DH has kept reviewing its structure to keep pace with the changes and meet challenges.

87. With increased awareness on public health in the community, there is also growing demand on DH services such as various vaccination programmes, health promotion, strategic action plans for prevention and control of non-communicable diseases (NCDs), and implementation of various public health-related subsidy schemes (e.g. Elderly Health Care Voucher (EHCV) Scheme and Colorectal Cancer Screening Programme) (see also **Chapter 2** on DH's services).

88. Insofar as PHC is concerned, a dedicated Primary Care Office (PCO) was set up in 2010 to support and co-ordinate the development of primary care in Hong Kong, with particular focus on co-ordinating public and private healthcare providers and other stakeholders in the implementation of population-wide policies and strategies to enhance primary care. Among other things, PCO is responsible for work relating to the development and updating of the RFs, maintenance and promoting the use of the Primary Care Directory (PCD), and promotion of the family doctor concept and/or family medicine practice. To allow better use of the expertise and resources, and enable HHB to better drive the continuous development of the PHC system in Hong Kong, the PCO has been integrated into the PHO of FHB since October 2019 (see **paragraph 93** below for functions of PHO).

89. At present, DH is the sole/lead agency for the administration of over 20 health-related ordinances in regulating, among other things, medical and therapeutic commodities, healthcare facilities, and harmful substances, to ensure public health and safety. With new statutes being introduced to step up protection of public health, and the advances in healthcare technologies in recent years, such as introduction of advanced therapies, development of genomic medicine, and increasing complexity in healthcare delivery and public expectation, DH has been ensuring organised efforts of the regulatory units and regimes in delivering relevant health policies, capacity building and responding to rapid development of healthcare technology and international standards. DH is also responsible for establishing and maintaining network with international and overseas health regulatory authorities.

90. In terms of premises of private healthcare facilities (PHFs) where doctors or dentists practise, DH is implementing the Private Healthcare Facilities Ordinance (Cap 633) in phases based on types of PHFs and their risk level. Application for hospital licences and day procedure licences have commenced since July 2019 and January 2020 respectively. For clinics, application for licence and request for letter of exemption will be announced in due course. Licensees of PHFs are required to comply with the regulatory standards covering governance, staffing, equipment and facilities related to the operation of the type of facilities as set out in the relevant codes of practice. Compliance with the Ordinance are monitored by conducting inspections, surveillance on medical events and handling complaints lodged by service users against these facilities with an independent statutory body, etc.

The Hospital Authority

91. Established 1990, HA is an independent statutory body established under the Hospital Authority Ordinance (Cap. 113). The Ordinance includes provisions specifying that HA should use the hospital resources efficiently to provide hospital services of the highest possible standard with the resources obtainable.

92. HA provides the public with a wide range of curative and rehabilitative services through its hospitals, specialist out-patient clinics (SOPCs), general out-patient clinics (GOPCs) and community outreach teams. HA is accountable to the Government through performance and quality targets and service indicators reporting to HHB, which funds HA and its services. It also provides stewardship on the number of PHC services under its umbrella, such as GOPCs and other programmes as outlined in **Chapter 2**.

Primary Healthcare Office

93. As mentioned in **Chapter 2**, the Government is committed to enhancing district-based PHC services in order to effectively change the current focus of healthcare services on treatment to alleviate the pressure on public hospitals by setting up DHCs in 18 districts progressively. Against this backdrop, the PHO was established under the then Food and Health Bureau on 1 March 2019 to oversee and steer the development of PHC services at the bureau level. PHO's initial focus was on the development of DHCs as a new model to cater for the needs and characteristics of the districts and enhance public awareness of healthy living, disease prevention and self-management of health. It has since then been tasked to spearhead the overall review and future development of PHC services.

Table 3.1

Major Initiatives of the Primary Healthcare Office
• To develop District Health Centres on a district-based and new model which leverages on public-private partnership and medical-social collaboration in providing primary healthcare service
• To enhance multidisciplinary, cross-sectoral and inter-organisational co-ordination in primary healthcare
• To develop, update and promulgate the reference frameworks for primary care setting;
• To maintain and promote the use of the Primary Care Directory;
• To promote primary healthcare, the family doctor concept and family medicine practice

STANDARD SETTING FOR PRIMARY HEALTHCARE SERVICES

Primary Care Directory

94. In 2010, the Government published the "Primary Care Development in Hong Kong: Strategy Document" (the Strategy Document) setting out the major strategies and pathways of action for improving the delivery of PHC services in Hong Kong (see also **Appendix C**). The establishment of the PCD was one of the major initiatives for the development of better primary care services in Hong Kong as laid down in the Strategy Document. The PCD is a web-based electronic database containing practice information and professional qualification of primary care providers in the community, which aims to:

(a) provide the public and primary care providers an easily accessible electronic database containing practice-based information of primary care professionals of various disciplines in the community; and

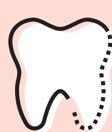
(b) facilitate co-ordination among different primary care providers functioning as multi-disciplinary teams to provide more comprehensive primary care services.

95. Currently, three sub-directories (medical practitioners, dentists and practising Chinese medicine practitioners (CMPs)) have been established under the PCD. PCD accepts enrollment from all registered practitioners of the three practices who are committed to providing directly accessible, comprehensive, continuing, co-ordinated and person-centred primary care services regardless of their discipline and practice focus. As at August 2022, there were 2 630 doctors, 228 dentists and 1 729 CMPs on the PCD.

96. In order to maintain their listings on the PCD, enrollees are required to comply with certain conditions for continuous medical education and development so as to encourage professional development and provide assurance to their quality of primary care services. Apart from continuous commitment to providing primary care services, an enrollee would be required to renew their Continuing Medical Education (CME) (applicable for medical practitioners) or Continuing Professional Development (CPD) (applicable for dentists) Certificate under each CME/CPD cycle. CMPs are also required to participate in the Continuing Education in CM for renewal of their practising certificates. The conditions for maintenance of listing in the PCD are summarised in **Table 3.2**.

97. As an incentive for the enrolment and enhancement of the quality of service provision, it has been a prerequisite for medical practitioners to be enrolled into the PCD in order to join certain government-subsidised healthcare initiatives, such as the Vaccination Subsidy Scheme (VSS) and participation in the DHC network.

Table 3.2

CONDITIONS FOR MAINTENANCE OF LISTING IN THE PRIMARY CARE DIRECTORY	
All	• An enrolled healthcare provider shall continuously provide directly accessible, comprehensive, continuing and co-ordinated person-centred primary care services
Registered Medical Practitioners	• An enrolled registered medical practitioner who is not taking Continuing Medical Education (CME) Programme for specialists shall participate in the "CME Programme for Practising Doctors who are not taking CME Programme for Specialists" approved by the Medical Council of Hong Kong (MCHK) and shall accumulate the required points for obtaining a yearly CME Certificate issued by the MCHK or for becoming qualified to quote the title "CME-Certified" as approved by MCHK after the end of each CME-cycle. • An enrolled registered medical practitioner who is a specialist included in the Specialist Register of the MCHK shall participate in and comply with the CME requirements relevant to his/her specialty as may be determined by the Hong Kong Academy of Medicine (HKAM).
Registered Dentist 	• An enrolled registered dentist who is not taking Continuing Professional Development (CPD) Programme for specialists shall participate in the "CPD Programme for Practising Dentists" approved by the Dental Council of Hong Kong (DCHK) and shall accumulate the required points for becoming eligible for the issue of a CPD Certificate by DCHK after the end of each CPD-cycle. • An enrolled registered dentist who is a specialist included in the Specialist Register of the DCHK shall participate in and comply with the CPD requirements relevant to his/her specialty as may be determined by the HKAM.
Registered Chinese Medicine Practitioners (CMPs) / CMPs with limited registration / Listed CMPs	• As per the prevailing legal requirements, registered CMPs shall participate in the Continuing Education in CM approved by the Chinese Medicine Council of Hong Kong and shall accumulate the required points for becoming eligible for the renewal of the practising certificate, which is also a requirement for enrolment in PCD. • An enrolled CMP with limited registration or listed CMP shall have records of participating in continuing education in CM.

Reference Frameworks

98. The development of RFs was another major initiative promulgated in the Strategy Document which aims to guide and co-ordinate efforts of healthcare professionals across different sectors in Hong Kong for the provision of continuing, comprehensive and evidence-based care in the community; empower patients and their carers; and raise the public's awareness on the importance of preventing and properly managing the major chronic diseases.

99. As in end-July 2022, four RFs comprising core documents and modules on topics about preventive care and disease management have been published (see **Table 3.3**). Of these, the RFs on HT, DM form an integral part of the secondary and tertiary prevention service protocol in the DHC, while the RF for older adults provides common reference for the Elderly Health Service under DH and the DHC's fall prevention programme. In addition, the modules under the RF for children have been adopted in parent education under MCHCs.

Table 3.3

TOPICS CURRENTLY COVERED BY REFERENCE FRAMEWORKS	
Diabetes Care for Adults	• Core Document • Module 1 – Framework for Population Approach in the Prevention and Control of Diabetes across the Life Course • Module 2 – Early Identification of People with Diabetes • Module 3 – Dietary Intervention for People with Diabetes • Module 4 – Recommending Exercise to People with Diabetes • Module 5 – Glucose Control and Monitoring • Module 6 – Drug Treatment for Hyperglycaemia • Module 7 – Drug Treatment in Type 2 Diabetic Patients with Hypertension • Module 8 – Lipid Management in Diabetic Patient • Module 9 – Diabetic Kidney Disease • Module 10 – Diabetic Eye Disease • Module 11 – Diabetic Foot Problems • Module on Smoking Cessation in Primary Care Settings
Hypertension Care for Adults	• Core Document • Module 1 – Framework for Population Approach in the Prevention and Control of Hypertension across the Life Course • Module 2 – Blood Pressure Measurement • Module 3 – Secondary Hypertension • Module 4 – Evaluation for All Newly Diagnosed Hypertensive Patients • Module 5 – Dietary Intervention • Module 6 – Exercise Recommendations to People with Hypertension • Module 7 – Drug Treatment for People with Hypertension • Module 8 – Annual Assessment • Module 9 - Lipid Management in Hypertensive Patients • Module on Smoking Cessation in Primary Care Settings
Preventive Care for Children	• Core Document • Module on Immunisation • Module on Development • Module on Childhood Injury Prevention • Module on Physical Growth • Module on Parent Empowerment – Booklet on Child Care Tips
Preventive Care for Older Adults	• Core Document • Module on Health Assessment • Module on Falls in Elderly • Module on Dental Health Care for Older Persons • Module on Visual Impairment • Module on Cognitive Impairment • Module on Common Mental Health Needs in Older Adults

THE CHALLENGES

100. An ageing population coupled with the COVID-19 epidemic has posed tremendous challenges to the public healthcare system. To safeguard public health and strengthen the provision of services, the Food and Health Bureau was revamped as the Health Bureau on 1 July 2022 which is dedicated to medical and health policies. HHB will press ahead with a host of priority initiatives, one of which being the implementation of the Blueprint.

101. However, as seen from the above, the existing health governance structure has not placed enough

emphasis on PHC. The health policy and decision making process has been fragmented without putting PHC at the centre of its policy focus. **A holistic approach at the policy level is required in addressing the systemic imbalances between PHC and secondary/tertiary healthcare in terms of policymaking, financing, manpower, regulation, and outcome monitoring. A co-ordinated approach at the implementation level is also required to ensure commitment to drive institutional changes and enhance cross-sectoral and inter-organisational co-ordination among PHC services in an integrated manner.**

102. At the same time, as we have again reiterated the importance of utilising the potential of the private healthcare sector, it is necessary that we maintain the standard and quality control of the PHC service sector as a whole. **There are yet available tools for the Government to leverage on with a view to ensuring standardisation and assurance of the quality of PHC services across public and private providers to ensure that the whole PHC system is driving towards the Government's overall PHC policy objectives and delivering the intended health outcomes.**

OUR AIM

103. To successfully implement various recommendations in this Blueprint, systemic changes in the governance structure should be introduced to enable a vision- and mission-led decision making process involving service assessment, resource allocation and co-ordination, generating intelligence and ensuring accountability. **Our aim is to demonstrate policy commitment and drive cross-sectoral and inter-organisational co-ordination among PHC services provided by public and private healthcare service providers at the community level**; and enhance standardisation and assurance of the quality of PHC services across sectors to ensure that the whole PHC system is delivering the intended health outcomes.

104. With the above intent, we propose the following –

RECOMMENDATION 3.1
Establishment of Primary Healthcare Commission

105. We consider that an overarching governance structure focusing on positioning PHC as a health system priority is essential to enable a vision- and mission- led policymaking process. An overarching governance body shall also provide oversight and bring together multiple agencies and align their efforts to ensure that the health system meets its targets, goals and duties in the delivery of services.

106. To this end, **the Government proposes to progressively transform the PHO currently under HHB into an overarching PHC governing body, the Primary Healthcare Commission**, to ensure effective and efficient utilisation of resources, promote seamless care across all government-subsidised healthcare services by ensuring effective cross-institutional and cross-sectoral collaboration, enhance monitoring of performance of different PHC services, and demonstrate the Government's commitment and support in developing a sustainable PHC system.

107. It is recommended that the Primary Healthcare Commission should be positioned to oversee –

(a) the **provision of PHC services**, including service planning and resource allocation through strategic purchasing supported by the newly established Strategic Purchasing Office (SPO),

(b) **standard and protocol setting** for both public and private service providers, quality assurance and **monitoring** of private PHC services, and

(c) the **training** of PHC professionals.

108. With gradual service integration as illustrated in Chapter 2, the Primary Healthcare Commission should be tasked to review the roles of different key service providers in PHC and enhance cross-sectoral and inter-organisational co-ordination. In terms of standard setting, patients requiring access to public secondary healthcare services should be subject to protocol-driven assessment at the PHC level to reduce service duplication and

abuse of public secondary healthcare services (see **Recommendations 3.2 and 3.3** below).

109. At the initial stage, the Primary Healthcare Commission would leverage on the existing manpower and structure relocated from both DH and HA to set up an executive arm for serving the dual functions of service standard setting and quality assurance, with support of a SPO in the procurement of PHC services in the private sector. It is envisaged that new legislation(s) would be required to provide the mandate and statutory powers for the Primary Healthcare Commission to implement the standards (as promulgated in **Recommendations 3.2 and 3.3**) on private PHC service providers other than through contract provisions. The Primary Healthcare Commission will be a change agent to facilitate cross-sector collaboration.

110. With the establishment of the Primary Healthcare Commission and the service integration plan as outlined in **Chapter 2**, the Government proposes to also realign the focuses and roles of DH and HA.

The Department of Health's Role

111. 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** (including regulation of drugs, healthcare facilities, tobacco and alcohol control). In addition, the core functions of DH in formulating and implementing public health strategies will also be strengthened, as well as monitoring and facilitating 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 society and public health.

112. Under the new role delineation, some of DH's direct PHC services would be gradually integrated into the Primary Healthcare Commission, depending on their respective service model, scale, and extent of service duplication with other service providers in the community. As a start, as the service model and scale of DHCs continue to grow and solidify, and given that there is a considerable extent of service duplication with DH, we propose certain PHC services to be gradually integrated with DH's, such as elderly health services, woman health services, health promotion, as well as other programme-based PHC services such as cancer screening (see **Chapter 2**). Meanwhile, other PPP programmes, such as various subsidised vaccination and screening programmes currently administered by DH, should be considered for integration under the Primary Healthcare Commission with partnership with private healthcare practitioners as appropriate upon SPO's review. The Primary Healthcare Commission and the newly set up SPO will recommend alternative approaches on service delivery in these areas with a view to allowing more cost-effective provision of healthcare services while maximising population health beyond the existing direct service delivery mode (see **Chapter 4**).

113. The re-organisation of DH upon establishment of the Primary Healthcare Commission will also enhance DH's capacity to keep abreast of and respond promptly to new developments and protect Hong Kong's public health. Focusing on public health regulatory affairs, the safety of healthcare services and products will be regulated in a more organised manner and the standard of healthcare industry is expected to be enhanced to safeguard public health. It will also enable the adoption of more co-ordinated efforts to achieve regulatory efficiency in meeting public demand and facilitating business operation.

The Hospital Authority's Role

114. On the other hand, while HA currently has also provided a range of PHC services to the community, with the establishment of the Primary Healthcare Commission, **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 PHC services (e.g. the GOPCs) should follow the policy direction from the Primary Healthcare Commission and only focus to serve as an essential safety net for the

population, especially those who lack the means to pay, as elaborated under **Recommendation 2.3**. The budget for respective PHC services should also be separated from HA's overall budget and put under the planning provision from the Primary Healthcare Commission.

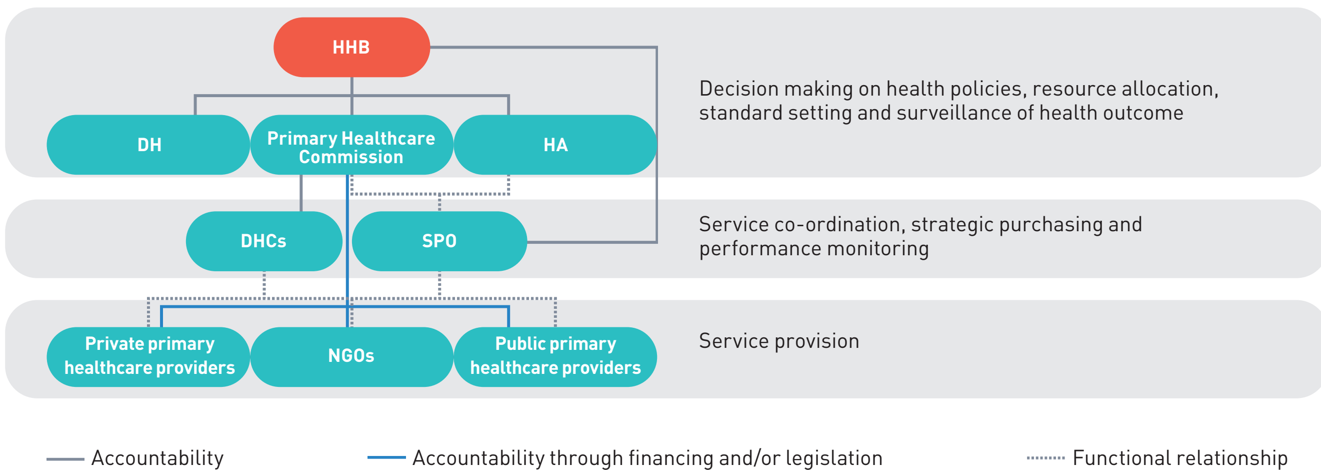
Strategic Purchasing Office

115. With the establishment of the Primary Healthcare Commission which assumes the role of resource allocation, it is necessary to look into most efficient ways in delivering PHC beyond the existing model through strategic purchasing. Strategic purchasing aims to maximise healthcare system benefits through an active, evidence-based process that 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.

116. To improve accessibility to quality health services for the general public and redress the imbalance between public and private healthcare services, the Government proposes to leverage on HA's and DH's existing manpower and resources to set up an SPO to oversee the development and implementation of programmes under strategic purchasing of healthcare services particularly at primary level under HHB's policy steer. Under the Primary Healthcare Commission's and HA's oversight respectively, resources are to be channeled more effectively towards quality, co-ordinated and continuous PHC with an emphasis on community-based, family-centric and prevention-oriented services, reduce service duplications, gaps inefficiencies and mismatches between the public and private sectors in PHC, and ultimately bring about optimised, co-ordinated and integrated care to individuals and families to maximise their health benefits and outcomes. Insofar as PHC is concerned, while the Primary Healthcare Commission should determine the services to be provided, SPO shall be responsible to assess strategically as to how and from whom the services are to be purchased as well as the incentive mechanism and optimum payment level in order to ensure overall cost-effectiveness. Details of strategic purchasing and SPO will be discussed **Chapter 4**.

117. The governance structure and functional relationship between different bodies under HHB is illustrated in **Figure 3.1**.

Figure 3.1
The proposed healthcare system governance structure and functional relationship



RECOMMENDATION 3.2

Standardised care for healthcare professionals participating in PHC service provision

118. As discussed in **Chapter 1**, the potential of the private PHC sector should be better utilised through improved co-ordination, resource allocation and policy steer. Private healthcare resources, if utilised properly, should alleviate the pressure on the public healthcare sector and thereby support a sustainable healthcare system.

119. During COVID-19, the Government has tapped into private healthcare resources for a number of initiatives against the epidemic, ranging from sentinel surveillance of suspected COVID-19 cases, the territory-wide COVID-19 vaccination programme, operation of community isolation facilities, to provision of COVID-19 drugs to patients in the community. Supported by the active involvement and participation of the private sector in operating service centres or provision of service in their private clinics, the Government was able to roll out these initiatives at light speed across the territory, which allowed us to gear up quickly in the face of the unprecedented healthcare crisis. This illustrates the importance and possible scope of how we could leverage the efficiency of private resources in the context of healthcare.

120. Experience from many developed countries shows that sharing population-based common clinical management models and protocols among healthcare providers in different settings facilitates the co-ordination of care, strengthens management continuity, promotes evidence-based practice and improves patient care [11]. To further promote development of PHC at the community level and establish policies and standards for various PHC service providers under a co-ordinated PHC system, we propose the following improvements to the existing PCD and RFs in order to transform them into levers for standardised care and quality assurance tools.

Primary Care Register

121. We recommend to redefine the role of the PCD into a Primary Care Register (PCR) which could serve as a central register for all PHC professionals under one umbrella for better monitoring, co-ordination and quality assurance. To transform the PCD into the PCR, the following aspects would be addressed:

(a) Strengthening the entry and maintenance requirement

122. Enrollment in the PCD is currently on a voluntary basis with no entry requirements except for holding registration licence and continuous medical education certificates. Also, apart from self-declaration, there is no clear definition to the primary care-related practice focus of the healthcare practitioners.

123. In order for the PCR to serve as a central database for better monitoring, co-ordination and quality assurance, the Government will review the entry and maintenance requirement to the PCR. We recommend to include PHC training as one of the key enrolment or maintenance requirement.

(b) Developing sub-directories for pharmacists and allied health professionals

124. In order to facilitate co-ordination of multi-disciplinary teams to provide comprehensive PHC services, the Government will continue developing sub-directories for pharmacists and other allied health professionals. The sub-directories will focus on enhancing collaboration of multiple disciplines and quality assurance of pharmacists and allied health professionals in supporting Government PHC initiatives. The sub-directories will be shared among PHC service providers and provided to patients to facilitate their choice upon referral.

125. It is suggested to first develop sub-directories for PTs, OTs and pharmacists in view of their extensive involvement in PHC for various medical conditions, in particular on chronic illnesses and long-term care. Sub-directories of other healthcare professionals (e.g. optometrists, nurses, speech therapists, dietitians, and other professionals who are not

subject to any statutory registration requirements) are recommended to be developed in a later phase.

(c) Adoption of standard care protocol and the use of (eHealth)

126. All PCR participants would be subject to quality assurance as set by the Primary Healthcare Commission. Among other things, they are required to follow the RFs promulgated by the Primary Healthcare Commission for handling specific chronic diseases (see **paragraphs 128 to 132**). Other quality assurance measures such as review and evaluation of practice, as well as performance indicators for PHC would be explored.

127. In addition, the use of eHealth for documentation of patients' records will become mandatory for healthcare providers on the PCR in order to facilitate continuity of care and allow better integration throughout the whole healthcare delivery process (see **Chapter 6** for details of eHealth).

REFERENCE FRAMEWORKS

128. We propose to establish the RFs as the standard care protocol in PHC services, particularly in government subsidised services, to enhance healthcare quality and facilitate multi-disciplinary care.

129. On top of the four RFs promulgated by the Government, covering HT, DM and preventive care for children and older adults in primary care settings (see **Table 3.3**), we will further develop and expand the applicability of the RFs to various disease groups with emphasis on patient empowerment and strengthening of multi-disciplinary care.

130. To support the future development of RFs with emphasis on patient empowerment and strengthening of multi-disciplinary care, the PHO has formed an **Expert Panel on Reference Frameworks** with experts of different backgrounds and specialties to advise the Government on the development, updating, promulgation and adoption of RFs in various settings. The PHO shall prioritise the development of new RFs and update existing RFs in a timely fashion having regard to the comments from the Expert Panel and international development. **Table 3.4** shows some of the potential topics of new RFs which are drawn up having regard to disease prevalence and international evidence on the effectiveness of PHC intervention. **The involvement of CM in the RFs will be further explored with a view to unleashing the potential advantage of CM in health management and facilitating multi-disciplinary collaboration in PHC settings (including pure CM and integrated Chinese-Western medicine approaches).**

Quality assurance of PHC practitioners

Table 3.4

Potential topics of new RFs
(a) common musculoskeletal problems
(b) woman's health
(c) chronic obstructive pulmonary disease
(d) common mental health needs
(e) chronic hepatitis

131. The Primary Healthcare Commission will be tasked to oversee the improvements on the PCR and RFs as mentioned in the above paragraph. To effectively utilise the above policy levers, the **Government proposes to require all family doctors and healthcare professionals participating in PHC service provision to be enlisted on the PCR and commit to use RFs**, including those enrolling in government-subsidised programmes such as the EHCV Scheme, various PHC PPP Programmes, vaccination programmes, population-wide screening programmes such as Colorectal Cancer Screening, as well as the CDCC Scheme) as mentioned in **Recommendation 2.2**, in order to provide quality assurance to users of PHC services, establish the "gold standard" for PHC service providers, and provide incentives for PHC professionals to adopt best practices and participate in co-ordinated care.

132. Through enrolling in PCR and compliance with the standards of RFs with legal mandate, continuous improvements in health service quality and performance of PHC practitioners and standards of PHC services is envisaged. With the extensive use

of eHealth and support by DHC's multi-disciplinary team, connection, communication and co-ordination between different healthcare providers in various settings and programmes will also be enhanced. A conceptual diagram on the governance of private PHC practitioners through various policy levers is set out in **Figure 3.2**.

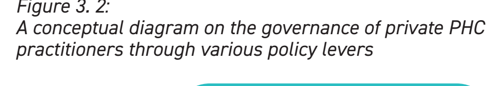
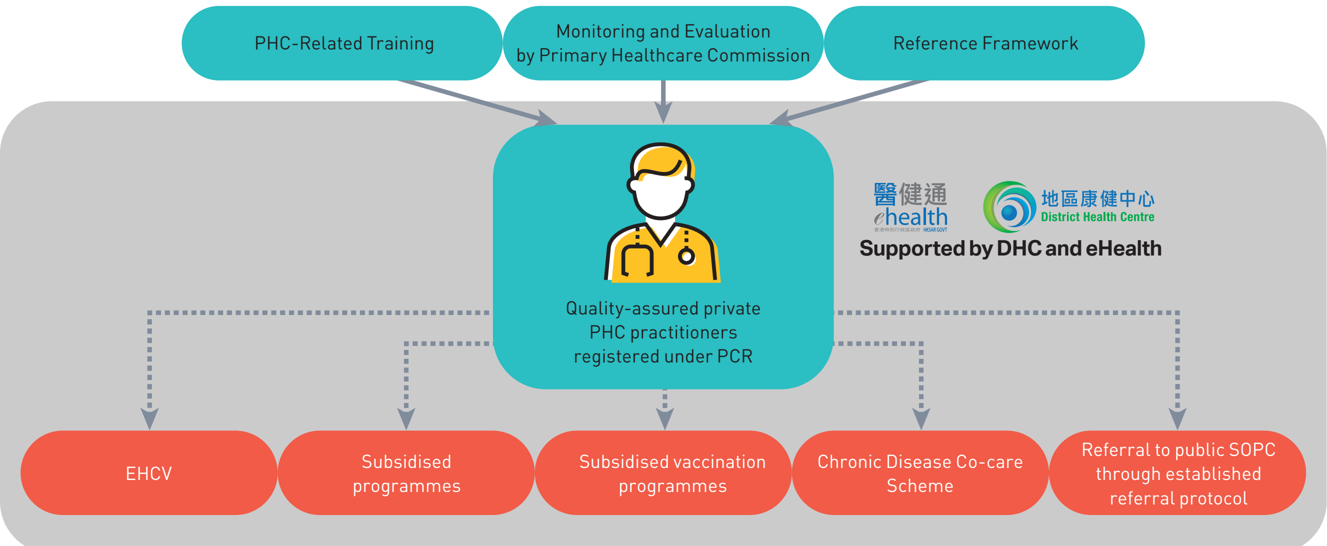


Figure 3. 2:
A conceptual diagram on the governance of private PHC practitioners through various policy levers



RECOMMENDATION 3.3

Establish an evidence-based, two-way protocol-driven primary-secondary referral mechanism

133. To address the problem of unclear patient pathway and multiple points of contact in the current healthcare system, GOPCs and the private PHC doctors should strengthen their role as the first contact point of the healthcare system and gate-keeper of access to secondary and tertiary care. A clear patient pathway and referral protocol are required so that the service model should be revamped to de-duplicate the functions of GOPCs and SOPCs; and for GOPCs and PHC doctors to gate-keep the access to the public secondary healthcare system.

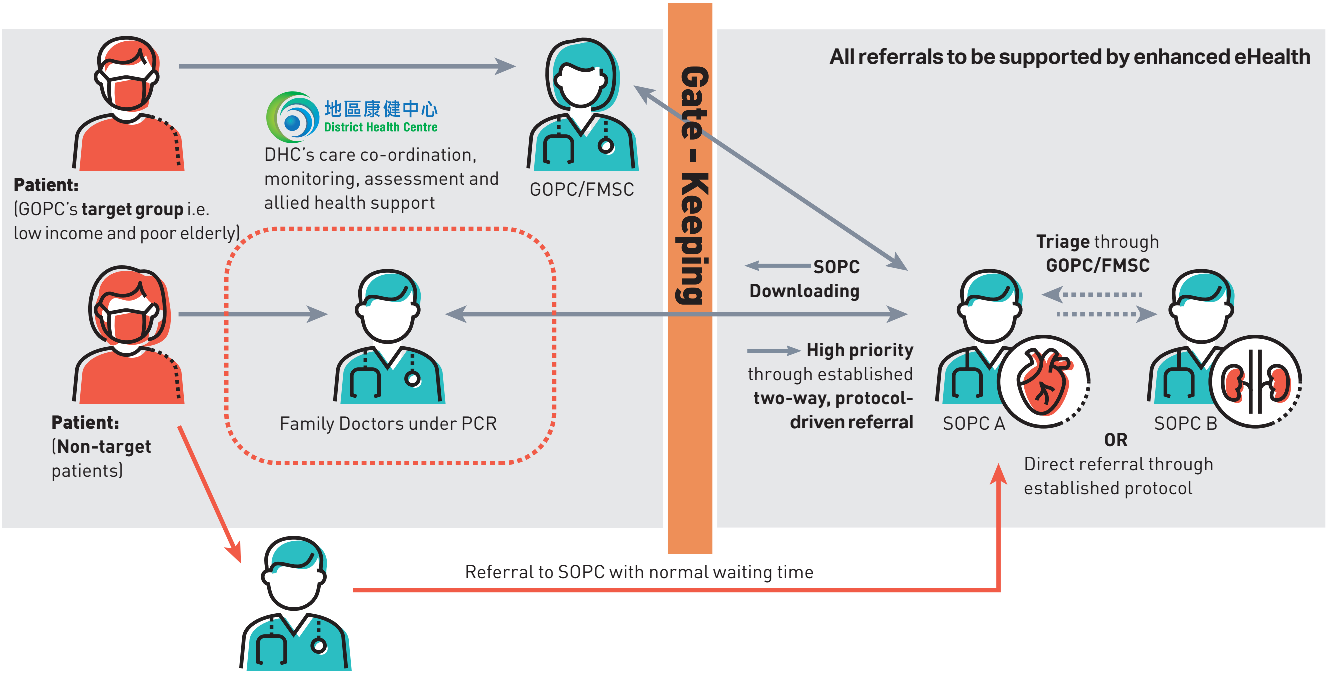
134. In order to achieve the above, an evidence-based, two-way protocol-driven referral mechanism, in particular for target chronic diseases, should be established for use by both the public and private sector to ensure only those warranted cases would be uploaded to the secondary level; whereas stable cases should be downloaded back to the primary level for ongoing care.

135. The referral protocol between primary and secondary/tertiary care would be supported by eHealth and developed by HA through the existing referral system in the public health system, starting with target chronic diseases (i.e. hypertension and diabetes mellitus). Upon its development, we **recommend to establish the primary-secondary referral mechanism between PHC service providers in both the public and private sectors with the specialist and hospital services,** emphasising the effective discharge of case management and gate-keeping role of PHC service providers, allowing timely and appropriate referral of patients in serious conditions by PHC doctors to specialists and hospitals for secondary

care, and allowing continuing follow-up, monitoring and disease management of patients in stable conditions by primary care doctors. In particular, the protocol shall be adopted by private PHC service providers participating in the CDCC Scheme under **Recommendation 2.2** for referrals to and from the public SOPCs.

136. Through effective gate-keeping and triage, **we envisage that the improved PHC 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 most of the time, and helping patients navigate each level of the healthcare system efficiently and thereby addressing the need, demand and the waiting time for SOPCs (see Figure 3.3).**

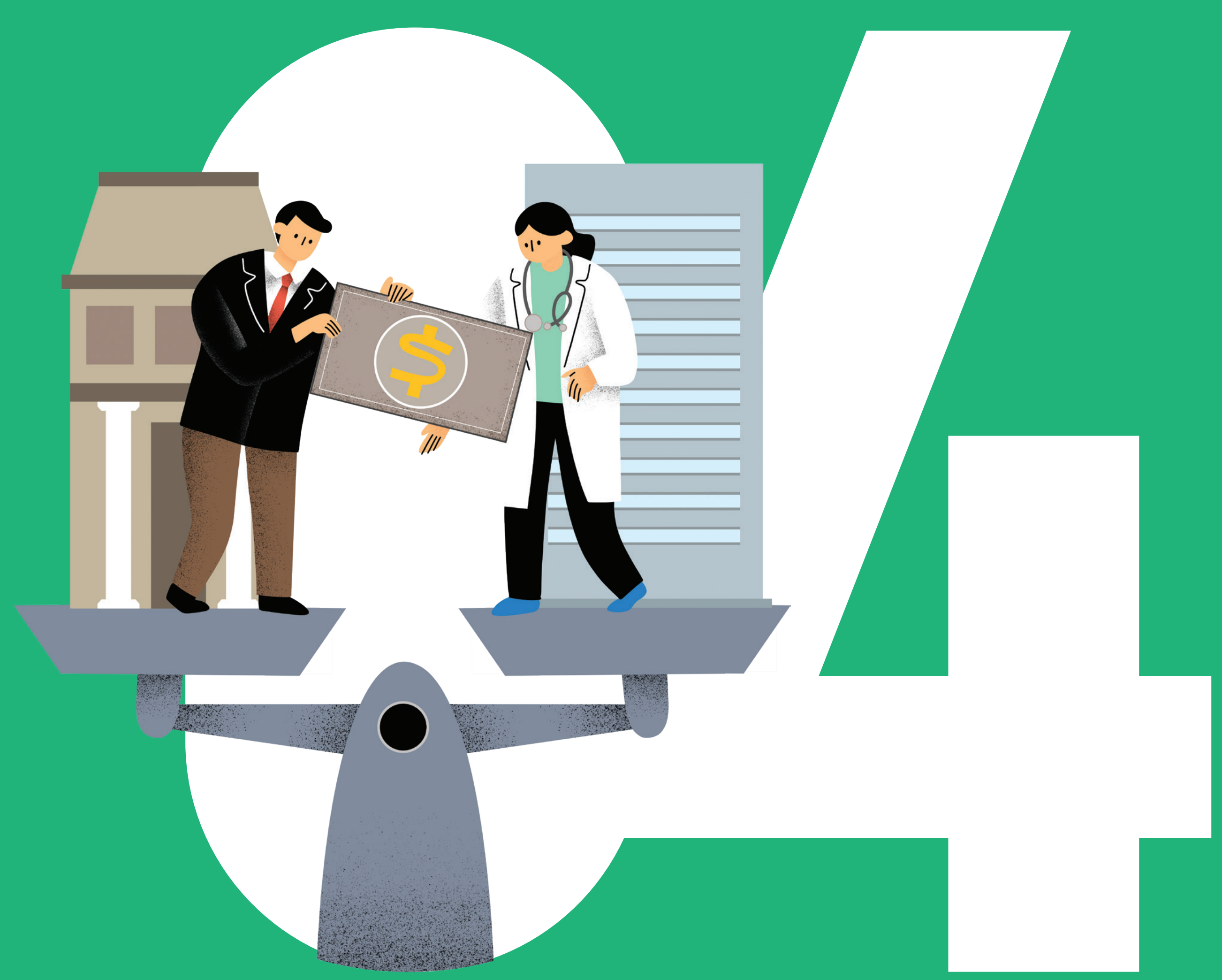
Figure 3.3
A conceptual diagram on the streamlined primary-secondary referral mechanism



137. In addition to the above, Hong Kong's first Chinese medicine hospital (CMH) is targeted to commence services by phases from 2025. CMH, as a flagship CM institution leading the development of CM, will provide subsidized primary and secondary/tertiary care services to the public. **The referral mechanism between CMH and relevant parties of the healthcare system (including but not limited to CM service providers) will be further explored. Moreover, mechanism that facilitate the interaction of CMPs with other healthcare professionals as well as the application of CM in PHC settings will also be considered.**

CHAPTER 3 - STRENGTHEN PRIMARY HEALTHCARE GOVERNANCE: ACTION PLAN					
	Action		Short	Medium	Long
3.1	**Primary Healthcare Commission**	• To expand PHO's establishment by introducing regional governance structure	■		
		• To expand PHO by leveraging on the existing manpower from DH and HA	■	■	
		• To establish the Primary Healthcare Commission with new legislation to provide the mandate and statutory powers for the Primary Healthcare Commission to implement the standards on private PHC service providers	■	■	
3.2	**Primary Care Directory**	• To develop sub-directories for pharmacists and other health professionals in the Primary Care Directory (PCD)	■	■	
		• To review the enrolment or maintenance requirement for the PCD	■		
		• To require healthcare practitioners joining subsidizedsubsidised programmes to register in PCD	■		
		• To establish the Primary Care Register (PCR), with the support of eHealth and legal backing by relevant ordinance		■	
	Reference Frameworks in Primary Care Setting	• To develop and expand the applicability of the Reference Framework (RFs) to various disease groups and to explore the involvement of CM in the RFs	■	■	■
		• To establish the RFs, with the support of eHealth backed by the Primary Healthcare Commission as the standard of care protocol for PCR healthcare practitioners		■	
3.3	**Primary-secondary referral mechanism**	• To devise the primary-secondary referral mechanism based on the existing referral system in the public health system	■	■	■
		• To promulgate relevant referral mechanism for the CDCC Scheme	■		
		• To implement the referral mechanism with the support of eHealth and backing by Primary Healthcare Commission in the public and private sectors		■	

CHAPTER



CONSOLIDATE PRIMARY HEALTHCARE RESOURCES

Public healthcare resources should be allocated to cater to the healthcare needs for all in a sustainable manner. As illustrated above, there will be a need to increase public expenditure on primary healthcare (PHC) services as an investment so as to achieve the target of reallocation of public health resources to achieve a sustainable health system. **A focus on chronic disease prevention and management is widely established as one of the most cost-effective ways to envisage sustainability of the healthcare system**. With the investment, it is expected that there will be an increase in the overall health expenditure in PHC from both the public and private sectors. **The additional resources required would have to be drawn either through reallocation from existing resources or injection of new ones.**

To improve accessibility to quality PHC for the general public and redress the imbalance between the public and private healthcare sectors, strategically the Government strives to optimise the utilisation of private healthcare resources and leverage on the private sector's capacity for providing PHC services, with a view to relieving pressure on the public sector and thereby enhancing the sustainability of the healthcare system. As recommended in the "Your Health Your Life" Healthcare Reform Consultation Document in 2008, to pursue PPP in healthcare in Hong Kong to subsidise the community to make better use of resources in the private sector for delivering service for patients, thus allowing the public healthcare system to continue to serve as an essential safety net for the population and be accessible to those who lack the means to pay, we have recommended that PHC services should be purchased from the private sector and patients should be partially subsidised to undertake preventive care in the private sector [19]. In this connection, **the Government proposes to improve the existing financing schemes, with various forms of subsidisation and PPP through strategic purchasing, to enhance the accessibility and affordability of PHC services in the community.**

Public Health Expenditure

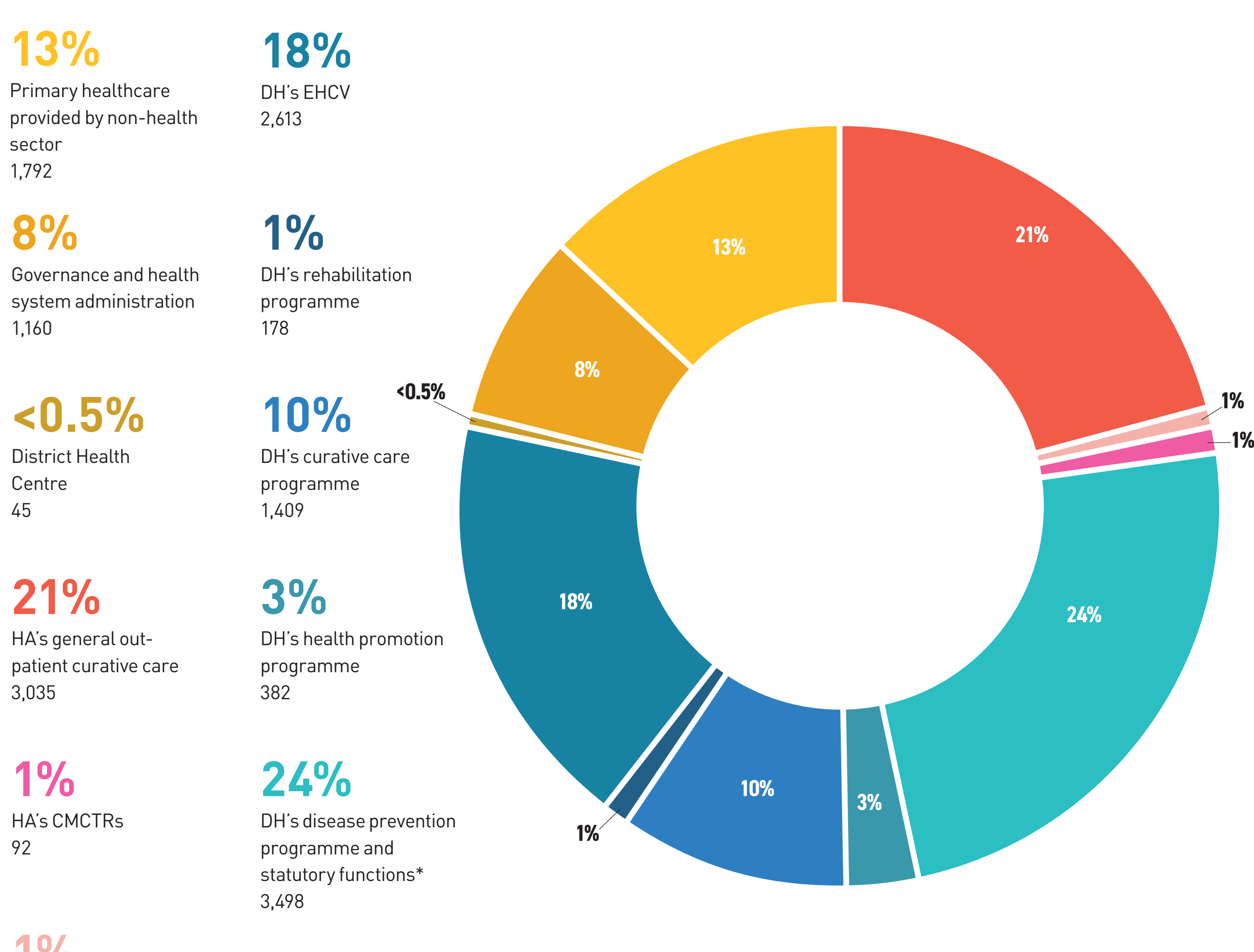
138. Over the years, the Government has made substantial and sustained investment to improve our PHC services. We have progressively achieved a substantial increase in recurrent health expenditure to almost $127.8 billion in the 2022-23 Estimates, amounting to 22.7% of total government recurrent expenditure. Nonetheless, according to the Domestic Health Accounts (DHA), around 83% of public health expenditure was spent on secondary and tertiary healthcare whereas only 17% was put on PHC in 2019/20 (See also **Chapter 1**) [7].

139. As elaborated at **Chapter 2**, the Government has been developing the public PHC system through strengthening the services of DH and HA, and subsidising NGOs in providing PHC services and launching public education. In recent years, the Government has launched various PPP programmes as recommended by previous consultation documents with a view to tapping into the private healthcare sector resources in meeting public PHC service demand. To enhance public awareness in disease prevention and self-health management, offering greater support for patients with chronic diseases, and relieving the pressure on specialist and hospital services, the Government has also launched the DHC scheme to enhance district-based PHC services throughout the territory progressively. The distribution of public PHC expenditure in 2019/20 (excluding COVID-19 related expenditure) is illustrated at **Figure 4.1**.

Figure 4.1:
The distribution of PHC expenditure in Public Health Expenditure

Distribution of public PHC expenditure in 2019/20 (HK$ million)

(excluded COVID-19 related expenditure)



* Excluded Governance and health system administration and EHCV expenditure

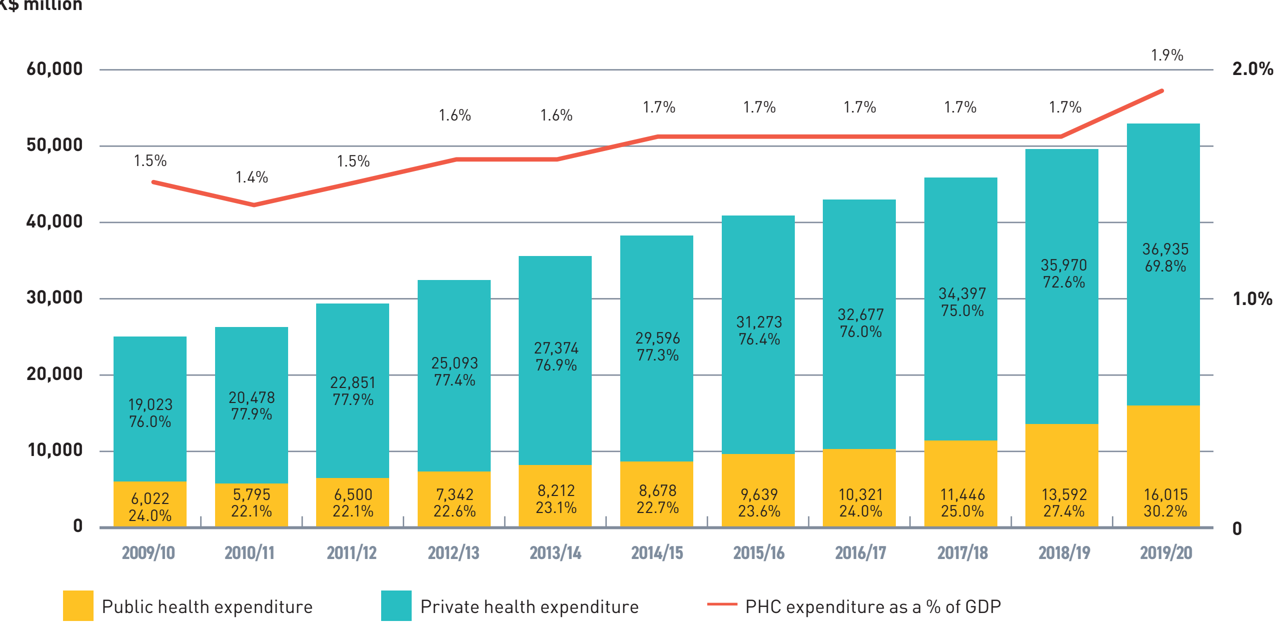
Source: DHA[7]

Private Health Expenditure

140. The private sector is the major provider of PHC services. As aforementioned in **Chapter 1**, public health expenditure and private health expenditure have been increasing in parallel. From 1989/90 to 2019/20, the total health expenditure has increased by 410% cumulatively in real terms. In 2019/20, the total health expenditure amounted to $188,709 million (6.7% of GDP) and per capita spending was $25,135, in which the overall PHC expenditure was $52,950 million, accounting for only 29.4% of current health expenditure. Private PHC expenditure made up around 69.8% of PHC expenditure in 2019/20 (**Figure 4.2**) [7].

141. The situation is different for secondary and tertiary care where the public sector is the major provider of services with private expenditure accounting for only 37% (**Figure 4.3**) or $47,415 million. Given the limited supply of services in private secondary and tertiary care, there would be limited scope for the Government to achieve savings in secondary and tertiary care, which are curative in nature, through PPP.

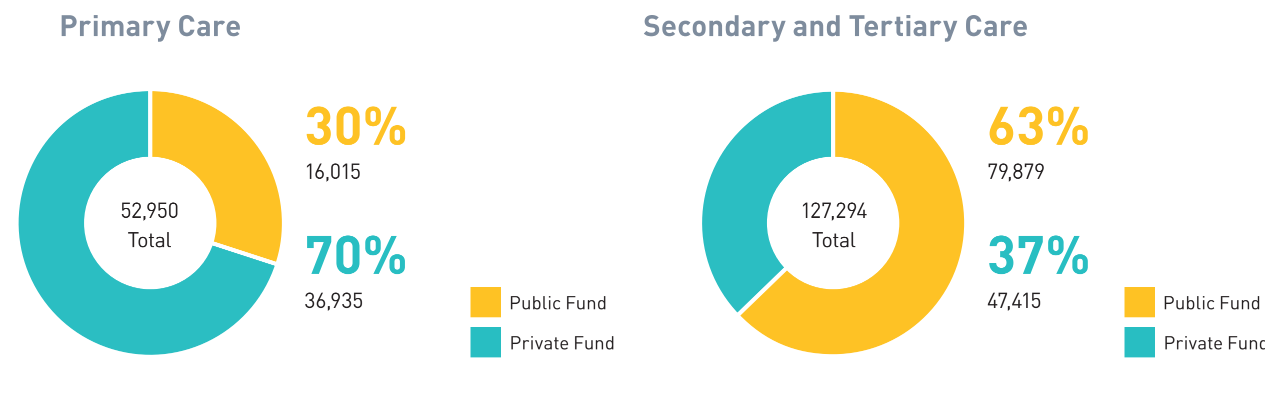
Figure 4.2:
Estimated PHC expenditure in the public and private sectors (in HK$ million) and the proportion of PHC expenditure as a % of GDP



Source: DHA

[4] While the Government does not have full grasp of the total private health expenditure on PHC in the market due to difficulty in differentiating PHC from other secondary out-patient services in the private sector, we have taken the assumption that 50% of out-patient curative care and 50% of administration of health financing are classified as PHC services in the private sector.

Figure 4.3:
Composition of Current Health Expenditure (in HK$ million), 2019/20



Source: DHA

142. As illustrated in **Chapter 1**, Hong Kong is facing a key and long-standing challenge on significant public-private imbalance in the entire healthcare system. While private services offer more choices and flexibility to patients, they all come with a price. Private healthcare services, which are paid mostly out-of-pocket[5], are more expensive than those in the public sector, and could be extraordinarily costly when more complicated and complex inpatient services are involved, and hence are not affordable to the majority of the general public.

143. On the other hand, the high quality and heavily subsidised public healthcare services have resulted in an ever-growing demand for public healthcare services, overstretching the public system as well as lengthening waiting time for services. In 2021, 87.2% of doctor consultations for chronic disease management were in the public sector, and there was an increasing trend of reliance on public services along with ageing of the population.

Public-private partnership

144. The sustainability of public healthcare services is at stake, and a better balance between the public and private sectors through Public-private partnership (PPP) is critical. Pursuance of PPP through a common platform between the public and private healthcare sectors involving medical specialists, general practitioners (GPs) and other disciplines of healthcare professionals would help address the current significant imbalance between the public and private sectors. Under PPP, patients are offered more choices and better means for private services, and the over-reliance on the public sector would be reduced. It also comes with other added benefits such as facilitating integrated medical care in a comprehensive, personalised and holistic manner; promoting healthy competition and collaboration between the public and private sectors; benchmarking service efficiency and effectiveness, and facilitating cross-fertilisation of expertise and experiences among medical professionals etc.

145. Over the years, the Government has rolled out different initiatives aiming to tap into resources of the private sector to enhance PHC development. Some examples of PPP, including DHC and GOPC PPP, have been discussed in **Chapter 2**. In addition, DH has also implemented various PPP initiatives, such as the Elderly Health Care Voucher (EHCV) Scheme, Vaccination Subsidy Scheme (VSS), and Colorectal Cancer Screening Programme (See **Table 4.1**).

146. These programmes have helped address service gaps and relieve pressure on the public sector. For the private sector, on top of business considerations, PPP programmes have provided connection, collaboration and cross-fertilisation of expertise with the public sector. For patients, these programmes have offered greater choices, shorter

[5] In 2019/20, 65.2% of private health expenditure and 77.1% of private health expenditure on PHC was paid by out-of-pocket payment, as mentioned in Chapter 1.

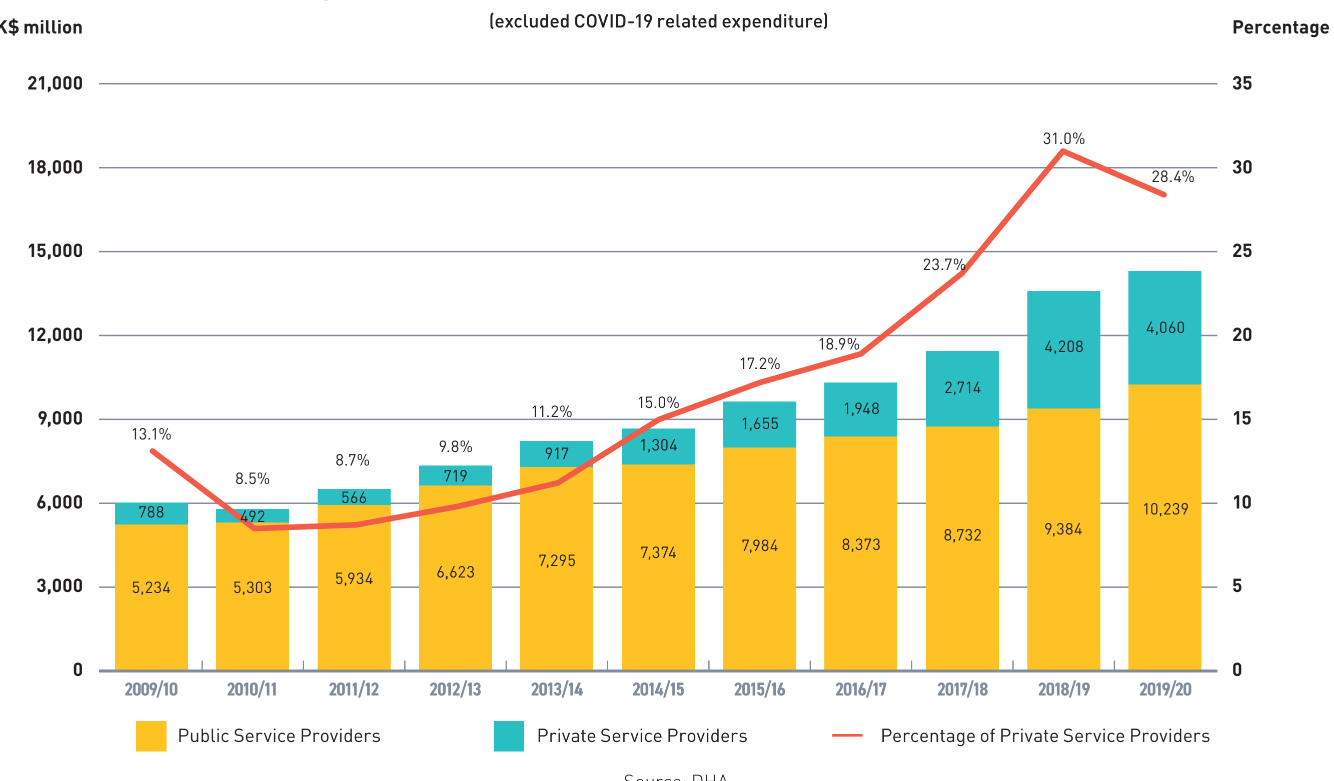
Table 4.1

KEY EXAMPLES OF PUBLIC-PRIVATE PARTNERSHIP SCHEMES IN PRIMARY HEALTHCARE		
	PPP	2022-23 Estimated Expenditure
Department of Health	Elderly Health Care Voucher Scheme	$4,376 million
	Colorectal Cancer Screening Programme	$150 million
Health Bureau (Health Bureau The Government of the Hong Kong Special Administrative Region of the People's Republic of China)	DHCs and "DHC Express" Scheme	$864 million
Hospital Authority	GOPC-PPP	$131 million

waiting time, better environment, personalised care and convenience at the same or lower fee, affordable co-payment, and in certain cases, they enjoy continuity of care under a family medicine concept. All these have assured that PPP is the right direction for further development based on the solid foundation established throughout the decade.

147. There is an increasing participation of private service providers in public PHC (**Figure 4.4**) that among the public expenditure on PHC, the share paid to private service providers has been increasing steadily over the past decade from only 8% in 2010/11 to about 28% (excluding COVID-19 related expenditure) in 2019/20.

Figure 4.4 :
Public health expenditure on PHC by public service providers and private service providers



Source: DHA

THE CHALLENGES

148. In order to shift the focus of the current health system towards PHC, there will be a need to expand expenditure on PHC services as an upfront investment so as to enable reallocation of healthcare resources from secondary/tertiary to PHC level and to attain better health outcome and 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.** Given the limited supply of services in private secondary and tertiary care, there would be limited scope for the Government to achieve savings in secondary and tertiary care, which are curative in nature, through PPP. The situation also leaves little room for the Government to relocate its resources on secondary/tertiary curative care into PHC notwithstanding its importance. In addition, the savings, or a reduced rate of increase in healthcare expenditure, with an investment in PHC, may only be realised in later years, as a result of deferring and reducing individual demand for secondary and tertiary care amongst an ageing population.

149. In considering utilisation of existing resources, one of the options is to rechannel the resources and improve existing PHC PPP or subsidised programmes in order to create synergy and direct private expenditure currently spent on PHC services (including individual direct expenses, medical benefits provided by employers or personal health insurance) to services that suits the concept of primary healthcare through relevant programmes supported by public resources under co-payment principle. **We acknowledge that the existing programmes were launched at different times and are implemented on a programme basis without strategic assessment of the overall service demand-supply gap**. Moreover, these programmes are planned, implemented, monitored, managed and financed respectively by DH and HA, and hence synergies among the programmes have been limited. **In addition, the nature of those PPP programmes, especially those more popular ones, are mainly those involving one-off subsidisation without cultivating ongoing patient-doctor relationship or fulfilling the co-payment principle.**

OUR AIM

150. To unleash more potential benefits of PPP in providing PHC services, strategic purchasing, a tool to complement the existing dual-track healthcare system through co-ordinating and integrating the purchase and administration of PPP initiatives in a strategic and holistic manner, should be put in place to drive changes towards a more optimal healthcare system. **In this connection, the Government aims to improve the existing financing schemes, with various forms of subsidisation and PPP through co-payment principle, to enhance the accessibility and affordability of PHC services in the community, and to channel resources more effectively towards quality, co-ordinated and continuous PHC with an emphasis on family-centric and prevention-oriented services, reduce service duplications, gaps, inefficiencies and mismatches between the public and private sectors PHC services, and ultimately bring about optimised, co-ordinated and integrated care to individuals and families to maximise their health benefits and outcomes.**

151. The Government strives to strategically optimise the resources of the private health sector to make wider use of market capacity by adopting the co-payment principle to implement PPP PHC services. Meanwhile, the Government will reposition public PHC services to serve the underprivileged groups. This will encourage citizens with higher affordability to use private PHC services subsidised by the Government, and at the same time allow public PHC services to focus resources on the underprivileged groups. Indeed, the objective of PPP programmes is not meant to outsource public services to the private sector, but to provide a choice for citizens who can afford the relevant co-payment and foster public-private collaboration, thereby optimising the use of resources in the healthcare system and enabling better patient care and outcomes.

152. **Overall, it is estimated that the implementation of various recommendations of the whole Blueprint for shifting the healthcare system towards prevention-oriented, family-centric PHC system will improve both the efficiency and financial sustainability of the healthcare system as a whole, as well as reduce the avoidable demand for the much**

more costly secondary and tertiary healthcare so as to achieve the optimal balance between primary and secondary/tertiary healthcare in total health expenditure. For instance, the proportion of primary and secondary/tertiary healthcare may progressively increase from 3:7 to 3.5:6.5, or even 4:6 in the long term with a view to alleviating the pressure on secondary and tertiary healthcare.

153. **As we proceed along this course, there will inevitably be upfront investment on PHC, but that may delay and alleviate the healthcare burden on secondary and tertiary healthcare brought about by ageing population and thus slow down the rate of increase in secondary and tertiary healthcare expenditure in later years. The commitment will be contributed by government expenditure, investment from the society and the citizens towards their personal health, and optimisation of existing PHC resources towards more cost-effective PHC with better health outcomes. The result of reduction in health service utilisation and subsequently, reduction in costs for hospitalisation associated with related complications will only come into effect at later stage.**

154. In consideration of the above, we propose the following to further enhance public-private collaboration and optimise the use of private healthcare resources to identify and support chronic patients, in order to release pressure on public specialist and hospital services –

RECOMMENDATION 4.1

Subsidisation for chronic disease screening and management

155. We have proposed in **Recommendation 2.2** the introduction of a CDCC Scheme to enhance the chronic disease management role of the private PHC sector by providing subsidisation for chronic disease patients. The number of HA patients with at least one common chronic diseases is projected to reach 3 million in the coming decade by 2039. **Through subsidising screening and management of targeted chronic diseases, we aim to achieve the target of early identification and appropriate intervention for these targeted patients at the community level in order to delay complications and alleviate the pressure on secondary and tertiary healthcare.** We believe that the financing levers and incentives provided are in line with our intended healthcare goals and health system changes as evidenced by cost-effectiveness studies on chronic disease management service model as mentioned in **paragraph 156** [20,21].

156. Local studies have shown the benefits and effectiveness of management of chronic disease at primary level in relieving healthcare burden. According to a local study on "Chronic Disease Screening Voucher and Management Scheme", the health system will save about 28% or 12.5 billion on direct healthcare expenses over 30 years and prevent a total of 47 138 mortalities through the provision of subsidised screening and management services for DM management in the private sector for individuals between the ages of 45 – 54 years for DM and prediabetes [22]. In accordance with the results, it is envisaged that the economic savings for subsidized screening and management for both HT and DM for all age groups would result in even greater healthcare savings and prevention of mortalities. Local cost-effectiveness studies also demonstrate that multi-disciplinary intervention of DM and HT programmes would save up to $11,200 (or 38% of the original cost ($ 29,451)) and $6,000 (or 33% of the original cost ($18,312)) per patient per year, amount to 5% and 10% of the total annual cost on all HA's services received by all HA patients in 2019/20 respectively [20, 21]. The cost reduction was driven by more effective preventive interventions at earlier stages of disease and more timely holistic treatment. The economic analysis also revealed that while initial investment of RAMP care is higher than usual care, the upfront cost is offset by the reduction in health service utilisation and subsequent reduction in costs for hospitalisation associated with related complications associated with these patients.

157. There will certainly be a number of variables affecting the final budget, for example, the number of current HA patients joining the private sector, the efficiency of identifying and screening at-risk individuals, and the market cost for HT and DM management which will be affected by

market competition and induced demand brought about by the Government subsidy. In particular, the co-payment level from participating patients of the CDCC Scheme, and the corresponding level of Government subsidy, would directly affect the willingness to pay of individuals. An optimum co-payment level will be a crucial factor affecting the success of the CDCC Scheme. According to a local study on "Chronic Disease Screening Voucher and Management Scheme" by a local think tank, 56.2% of respondents were willing to pay at a range from $51 to $200 per consultation for the co-payment for chronic disease management [22]. In this connection, thorough research and programme design are required to achieve the intended healthcare goals and health system changes, especially due to the prevailing low price transparency of the private PHC sector.

158. Regardless of the above which will be subject to further studies and analysis upon detailed design of the Programme by the SPO (see **Recommendation 4.3**), it must be emphasised that the financing model of the Programme should be based on co-payment so as to encourage members of the public, as the manager of their own health, to bear part of the costs of the services. While co-payment is required for the Programme, GOPCs under **Recommendation 2.3** will be repositioned to focus on services for the poor elderly and the low-income families. We believe that such an arrangement would achieve market segmentation and improve healthcare efficiency through a targeted, streamlined approach.

RECOMMENDATION 4.2
Reallocation of primary healthcare resources – the Elderly Health Care Voucher

159. The Government has implemented the EHCV Scheme since 2009. Currently, the 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 PHC services that best suit their health needs. The Scheme aims to enhance PHC for the elderly persons and provide them with an additional choice of service, thereby supplementing the existing public healthcare services and making it easier for the elderly persons to receive healthcare services from their chosen service providers. The estimated expenditure for implementation of the Scheme in 2022-23 is $4,375.8 million.

160. The EHCV Scheme utilises about 18% of the existing public PHC resources annually, after excluding COVID-related PHC expenditure. According to the comprehensive review of the EHCV Scheme in early 2019, the utilisation of EHCV is heavily skewed towards acute services rather than disease prevention or chronic disease management. Following the review, the Government progressively rolled out various measures to enhance 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.

161. EHCV will continue to support the Government's policy objective of promoting PHC, support elders' health needs, assist to enhance their awareness of disease prevention and self-management of health, as well as complement the development of DHCs. On this premise, we will strive to ensure the optimisation of resources invested in the Scheme. In addition to considering the impact on public finances, we also need to ensure that the Scheme can effectively achieve the objective of promoting PHC. To achieve the PHC objective as set out in this Blueprint and finance part of the resources required for implementing **Recommendation 4.1**, **it is proposed that the EHCV Scheme should be improved to direct resources towards PHC services with an emphasis on strengthening chronic disease management and reinforcing the different levels of prevention.**

162. 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. The additional amount should also be used for those designated services. 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 PHC services for disease prevention and health management more effectively.

163. Apart from the above, we will continue to keep in view the operation of the 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 PHC services for disease prevention and health management.

RECOMMENDATION 4.3

Reallocation of primary healthcare resources – strategic purchasing of primary healthcare services

164. A carefully designed and balanced financing system, comprising government policies, safety net, healthcare vouchers, user co-payment, self-financing services, insurance, etc., would play an important role in driving towards an optimal healthcare system addressing the population's healthcare needs. To achieve all these, strategic purchasing should come into play.

165. The Government intends to use strategic purchasing as a tool to complement Hong Kong's existing dual-track healthcare system through bridging the segmented public and private sectors so that PPP initiatives could be procured and administered in a more strategic and holistic manner. It will help address priority duplications and service gaps between the public and private sectors, reduce service inefficiencies and mismatches, and ultimately bring about co-ordinated and integrated care to patients which would maximise their health benefits.

166. With strategic purchasing, a range of differential healthcare products in the form of strategic purchasing programmes (SPPs) having corresponding differential prices and subsidies between the two sectors will emerge, so that greater choices with better coverage and continuity of care could be offered to patients to suit their personal health needs, preference and affordability. The programmes or services should be reliable through accreditation and credentialing. At the higher level, a better balance between demand and supply of services, as well as between the public and private sectors could be achieved, which would contribute to the long-term sustainability of the healthcare system in Hong Kong.

Table 4.2

Focus of Strategic Purchasing	
(a)	To build better PHC systems
(b)	To address pressure areas in the public healthcare system
(c)	To address mismatch in supply and demand
(d)	To contain health cost escalation
(e)	To pool healthcare resources
(f)	To better utilise healthcare resources towards better health outcomes

Table 4.3

SCOPE OF SERVICE OF STRATEGIC PURCHASING OFFICE (SPO)	
Population-wide Programmes	• Population-wide Programmes are programmes that are designed on population-wide basis under defined scope of target providers and clients, aiming to achieve the Government's healthcare policies and objectives • SPO will explore, plan, launch, administer, review and evaluate the programmes according to the programme policy objectives • Partnership and synergy with DHCs under the Health Bureau and the CMCTRs would be planned • In view of the fact that the resources of Hong Kong's CM sector are mainly concentrated in the private market, we will also explore enhancing CM PHC services by, inter alia, resource allocation through strategic purchasing
HA Patient Programmes	• HA Patient Programmes are programmes that would cover HA patients, aiming to achieve the Government's objective of building an integrated healthcare system with respect to HA services • All existing HA PPP programmes will migrate to SPO by phases for management and administration
Elderly Health Care Voucher (EHCV) Scheme	• EHCV Scheme will migrate to SPO for management and administration • SPO will leverage on the EHCV Scheme and other available financial resources to build incentives in the SPPs with a view to develop desirable health seeking and health providing behaviour toward targeted health outcomes for the population

167. We have proposed in **Recommendation 3.1** that the proposed Primary Healthcare Commission should be positioned to oversee the provision of PHC services, including service planning and resource allocation through strategic purchasing. With the setting up of the Primary Healthcare Commission, it should be tasked to look into the most efficient ways in delivering PHC which do not necessarily mean direct service delivery. On behalf of the Primary Healthcare Commission, the SPO will **oversee the development and implementation of SPPs at primary care level**, so as to channel resources more effectively towards PHC, reduce service duplications, gaps, inefficiencies and mismatches between the public and private sectors in PHC. **A purchaser-provider split service delivery model should be adopted to bring about competition among providers and improvement in service delivery in terms of greater organisational flexibility and responsiveness of services to patient needs.** Comprehensive and long-term vision should be formulated for more cost-effective use of public resources to meet healthcare needs and alleviate service burden of the public healthcare system.

168. Under the new role delineation between DH and the Primary Healthcare Commission, some of DH's direct PHC services would be integrated into the Primary Healthcare Commission by phases. The Primary Healthcare Commission and the newly set up SPO will recommend the best approach on service delivery in these areas with a view to allowing more cost-effective provision of healthcare services while maximising population health. **As a result, there should be room for the existing PHC resources to be reallocated more efficiently.**

RECOMMENDATION 4.4
Land resources for primary healthcare services

169. Aside from financial resources, another important angle in developing PHC is the availability of land resources. In the course of developing DHCs in 18 districts, one of the major hurdles encountered was to identify suitable space for the provision of services at the community level. Currently, responsibility for land inventory management, projection of demand in relation to public PHC facilities is scattered within DH and HA which may result in a lack of overview and overall co-ordination in planning, leading to sporadic if not haphazard development and use of premises, posing obstacles to long-term development and consolidation as well as sustained renewal of health facilities.

170. Apart from public healthcare facilities, we consider that land resources would be an important incentive for the development of PHC in the community, especially in terms of facilities planning for private or NGO PHC services. As opposed to secondary and tertiary care facilities which usually involve larger scale developments and comparatively smaller in number, and where convenience of location to local residents may not be a prime consideration, private or NGO primary care services are mainly accommodated in commercial premises or premises owned or rented by NGOs. The availability of affordable space could be a factor limiting the provision of accessible PHC services. **We propose to pursue development and redevelopment of government buildings and premises for healthcare facilities at the community level and to examine the feasibility of providing accommodation space therein for certain private healthcare service providers or NGOs to provide PHC services, in order to facilitate their development as part and parcel of the district-based community health system, and the delivery of seamlessly integrated, co-ordinated and continuous PHC through co-location.**

171. In tandem, for better planning and development of PHC service facilities, we propose to a clear delineation of the following tasks and roles on the management of health-related land resources under the proposed Primary Healthcare Commission:

(a) **Redevelopment:** Redevelop older Government buildings with outdated PHC facilities or in dilapidated conditions and maximise the development potential.

(b) **Consolidation:** Consolidate and co-locate PHC facilities at convenient locations including NGOs operated ones.

(c) **Earmarking:** Provide space for PHC facilities including private and NGO services under relevant or new policies to be formulated in support of PHC development.

(d) **Synergising:** Take into account the nature of health facilities that may benefit from co-location for synergies.

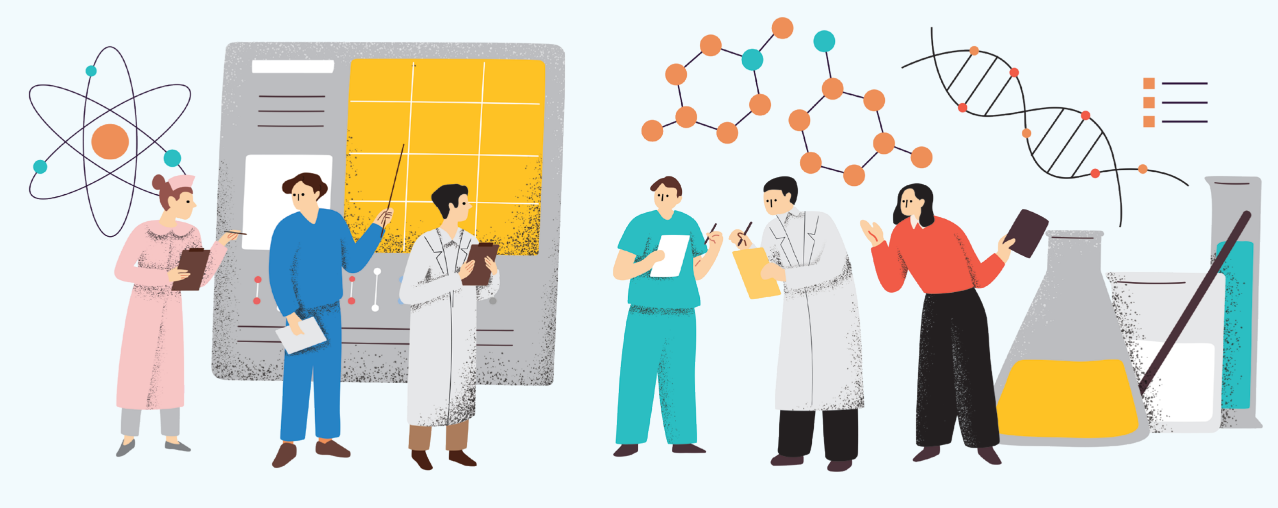
(e) **Dovetailing:** Dovetail with impending or possible service re-organisation plans, as well as other development or redevelopment programmes.

CHAPTER 4 - CONSOLIDATE PRIMARY HEALTHCARE RESOURCES: ACTION PLAN					
	Action		Short	Medium	Long
4.1	**CDCC Scheme**	• To conduct market research and programme design for the CDCC Scheme			
		• To review the positioning and interfacing of the GOPC PPP and the CDCC Scheme in terms of pricing, drug list, subsidisable conditions and referral criteria, etc.			
		• To transition the GOPC PPP to CDCC Scheme			
		• To conduct ongoing review and evaluation on the CDCC Scheme			
4.2	**EHCV**	• To review the applicability of ECHVs for other PHC programmes besides DHC			
		• To designate a certain amount of Elderly Health Care Voucher for preferred use related to PHC purposes and self-registered family doctors			
4.3	**Strategic Purchasing Office**	• To set up the Strategic Purchasing Office (SPO) by integrating the existing Health Care Voucher Division of DH and Service Transformation Department (PPP office) of HA			
		• To oversee the development and implementation of PHC programmes under strategic purchasing			
		• To conduct ongoing review and evaluation on the SPPs			
		• To explore enhancing Chinese medicine PHC services by resource allocation through strategic purchasing			
		• To set up the community drug formulary to support patients			
4.4	**Land Resources**	• To set up a centalised inventory of healthcare facilities to identify and project supply-demand gap of land resources for PHC services			
		• To explore room to consolidate and co-locate health service facilities especially those relating to PHC services			
		• To devise a policy for land premium concession by non-profit making organisations delivering PHC services			
		• To explore providing space for PHC facilities for the use of healthcare operators (including those to be operated by NGOs) under relevant policies			

CHAPTER

REINFORCE PRIMARY HEALTHCARE MANPOWER

The sustained delivery of quality and adequate PHC services relies on a stable and sufficient supply of qualified PHC manpower with the necessary knowledge, skills and attitude, who embrace the concept of multi-disciplinary teamwork in PHC in the community. The training and enhancing of the role of PHC professionals is essential to ensure adequate and quality manpower supply for an effective PHC system in Hong Kong.



172. Our healthcare system is supported by a team of dedicated healthcare professionals. As at end of 2020, there are over 117 000 healthcare professionals from the 13 professions which are subject to statutory registration.

Table 5.1

Number of Registered Healthcare Professionals	
Doctors	15 546
Chinese Medicine Practitioners	10 535
Dentists	2 706
Dental Hygienists	531
Nurses	64 026
Midwives	4 450
Pharmacists	3 181
Occupational Therapists	2 783
Physiotherapists	3 954
Medical Laboratory Technologists	4 224
Optometrists	2 273
Radiographers	2 673
Chiropractors	287

Source: Healthcare Manpower Planning and Projection by HKU

Figure 5.1: Number of registered healthcare professionals

Midwives; 4 450; 3.8%
CMPs; 10 535; 9%
Pharmacists; 3 181; 2.7%
Doctors; 15 546; 13.3%
Dentists; 2 706; 2.3%
Dental Hygienists; 531; 0.5%
Nurses; 64 026; 54.6%
Optometrists; 2 273; 1.9%
Chiropractors; 287; 0.2%
Physiotherapists; 3 954; 3.4%
Radiographers; 2 673; 2.3%
Occupational Therapists; 2 783; 2.4%
Medical Laboratory Technologists; 4 224; 3.6%

Source: Healthcare Manpower Planning and Projection by HKU

Healthcare Manpower Supply

173. The Government has been adopting a multi-pronged approach to enhance healthcare manpower. At present, local graduates from University Grants Committee (UGC)-funded programmes and self-financing programmes are the primary source of manpower supply for most of the healthcare professions, supplemented as necessary by qualified non-local ones through established mechanism in the short term. In light of an ageing population, general shortage of healthcare manpower, and expanding provision of healthcare services, the Government has further increased UGC-funded healthcare training places for doctors, nurses, pharmacists, and allied health professionals since the 2009/10 triennium.

Primary Healthcare Training

174. Currently, PHC elements have been embedded in the curriculum of most of the relevant undergraduate and postgraduate healthcare training programmes.

175. To develop an effective PHC system, we recognise the need to ensure adequate and quality supply of PHC manpower with sufficient knowledge, skills and comprehensive understanding of the multi-disciplinary PHC team and the role of each type of healthcare professionals under PHC settings including the DHC network. Training for PHC professionals is important to enable the delivery of comprehensive and sustainable PHC services under a team approach.

176. To facilitate the territory-wide rollout of DHCs, PHO has been working with the Hong Kong College of Family Physicians (HKCFP), the College of Ophthalmologists of Hong Kong (COHK), the Hong Kong Academy of Nursing (HKAN), and the Hong Kong Polytechnic University (PolyU) to develop relevant PHC training courses for enhancing the skills and encouraging healthcare professionals to play a more active role in the development of PHC for Hong Kong. With an emphasis on medical-social collaboration, PHO has also worked with The Hong Kong Council of Social Service on a certificate course in "Primary Healthcare for Social Workers". As an incentive for enrollment, the Government reimburses 25% of the course fee for participants who have successfully completed the designated training course. A list of those training courses can be found in **Table 5.2**.

Table 5.2

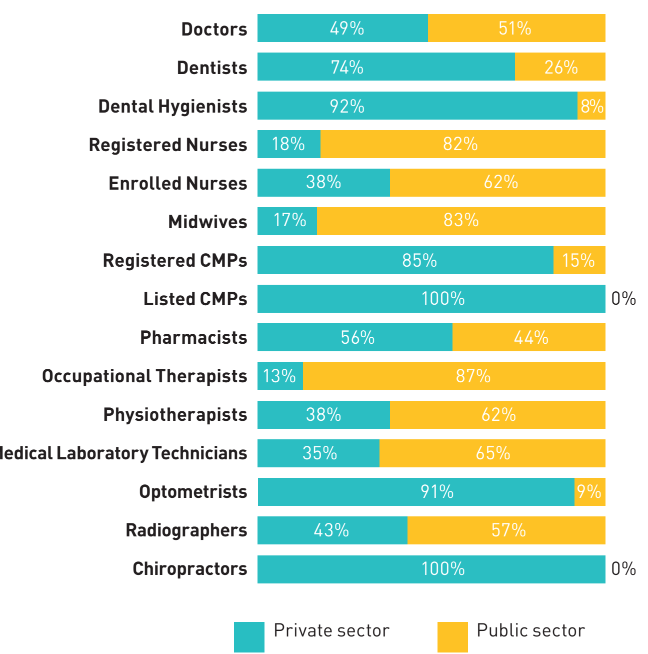
PRIMARY HEALTHCARE TRAINING COURSES CURRENTLY OFFERED FOR PROFESSIONALS

Profession	Courses
Medical Practitioner	**The Hong Kong College of Family Physicians (HKCFP)** • Certificate Course in Essential Family Medicine • Diploma Course in Family Medicine **HKCFP and the College of Ophthalmologists of Hong Kong (COHK)** • Certificate Course in Ophthalmology for Primary Care Doctors
Nurse	**The Hong Kong Academy of Nursing (HKAN)** • Post-registration Certificate Course in Primary Health Care Nursing (DHC Module)
Physiotherapist	**The Hong Kong Polytechnic University (PolyU), The Spastics Association of Hong Kong (SAHK) Institute of Rehabilitation Practice and the Hong Kong Physiotherapy Association** • Professional Certificate in Primary Healthcare in Community Care Context for Physiotherapy
Occupational Therapist	**PolyU and the Hong Kong Occupational Therapy Association (HKOTA)** • Professional Certificate in Primary Healthcare for Occupational Therapy
Social Worker	**The Hong Kong Council of Social Service** • Certificate in Primary Healthcare for Social Workers

THE CHALLENGES

177. As recommended in the Report of the Strategic Review on Healthcare Manpower Planning and Professional Development published in 2017, the Government conducts a healthcare manpower projection exercise every three years to update the supply and demand figures of different healthcare professionals, in step with the triennial planning cycle of the UGC. The last round of the manpower projection exercise was conducted in 2020 and the results were announced in March 2021. According to the latest manpower projection published in March 2021, as compared with the results in 2017, the shortage of doctors, nurses, dentists, physiotherapists (PTs), medical laboratory technologists, optometrists and radiographers persists, with gaps further widened for the shortage of doctors and nurses in the short and medium-term [23]. In particular, the numbers of doctors and nurses per 1 000 population are fewer in Hong Kong as compared with other high income economies [24, 25].

Figure 5.2:
Distribution of ealthcare professionals in the private sector and public sector



Source: The DH's Health Manpower Survey
(consolidated data from 2014 to 2018)

178. Against the backdrop of the general shortage of healthcare manpower in Hong Kong, the challenge of attracting and retaining healthcare professionals, especially medical practitioners, in the practice of PHC is even more acute in view of the comparatively stable career path in the secondary and tertiary care sectors which is largely dominated by the public healthcare system.

OUR AIM

179. Sufficient healthcare manpower is a must for the development of an effective PHC system. **Our aim is to ensure adequate and steady supply of PHC manpower with the necessary knowledge, skills and attitude, embracing the concept of multi-disciplinary teamwork in PHC, so as to cope with an ageing population. We also aim to progressively enhance the role of CMPs, community pharmacists as well as other PHC professionals in the delivery of PHC services,** through undergraduate and postgraduate education and clinical practice in PHC, and professional-driven and evidence-based development of care models and protocols under the aegis of the Primary Healthcare Commission with necessary resource allocation and referral pathways as part of the co-ordinated and continuous PHC at community level.

180. To strengthen the PHC workforce and professional training for PHC professionals against the above backdrop, we propose the following –

RECOMMENDATION 5.1
Ensure adequate supply of primary healthcare-related professionals

181. The Government has been adopting a multi-pronged approach to enhance healthcare manpower with a view to supporting the development of various healthcare services. Based on projections, the Government has further increased the number of training places for medical students from 530 to 590 per cohort in the 2022/23 to 2024/25 triennium. The Government has also invited self-financing institutions to provide a total of 180 additional training places for nursing students in the 2022/23 academic year.

182. To ensure sustainable supply of PHC manpower, especially against the backdrop of a general shortage of healthcare manpower in Hong Kong, the Government will adopt the following strategies going forward –

(a) in the short run, the Government will increase the number of UGC-funded healthcare training places in the coming triennium cycles and subsidise designated full-time locally accredited self-financing undergraduate and postgraduate programmes;

(b) it will invite the relevant professional Boards and Councils of healthcare professionals to consider increasing the weighting of PHC in their accreditation and placement programme during the regular review of the existing undergraduate and postgraduate curriculum; and

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

Doctors

183. Among all practices, family doctors play a pivotal role in providing comprehensive, continuous, whole person care to the citizens, from prevention to treatment of diseases. Family doctors also represent an important node in the PHC system, not only by providing health assessments and identification of risks to facilitate early intervention and performing diagnosis, but also by offering comprehensive, continuing and holistic care of individual patients in collaboration with other healthcare professionals under the concept of multi-disciplinary care.

184. To alleviate the shortage of doctors in the public healthcare system, the Government secured the passage of relevant legislative amendments in October 2021 to create a new pathway, namely special registration, for qualified non-locally trained doctors to obtain full registration in Hong Kong, subject to certain requirements or criteria being met. In accordance with the amended Medical Registration Ordinance (Cap. 161), the Registrar of Medical Practitioners (i.e. the Director of Health) announced in April 2022 and June 2022 the first two batches of a total of 50 medical qualifications recognised by the Special Registration Committee.

185. According to the 2018 Health Manpower Survey conducted by DH, among the active doctors enumerated who were trained in one field of specialist training, only about 8% were trained as family medicine specialist [26]. Whilst a family doctor in Hong Kong can be a GP, a family medicine specialist or any other specialist, the Government will continue to strengthen and enhance resources to enable PHC doctors to receive family medicine-related training. In addition, **with the new registration pathway stated above, the Government looks forward to attracting qualified non-locally trained PHC professionals, especially family doctors, to practise in Hong Kong.**

Other healthcare professionals

186. For healthcare professionals such as nurses and allied health professionals, apart from the usual undergraduate programmes, the Government will support some healthcare-related taught postgraduate programmes from the 2023/24 academic year onwards to facilitate first degree-holders from non-healthcare disciplines to step into the healthcare sector and become healthcare professionals. Furthermore, we will provide an additional 500 designated places under the Study Subsidy Scheme for Designated Professions/Sectors for healthcare-related self-financing undergraduate programmes per cohort starting from the 2023/24 academic year to enable more eligible students to pursue their studies in healthcare-related disciplines. The Government is working out the details of the above-mentioned initiatives with the UGC-funded universities and the self-financing institutions, and will encourage them to train more healthcare professionals required for the public healthcare system.

RECOMMENDATION 5.2

Enhance primary healthcare-related training for healthcare professionals and promotion of a multi-disciplinary approach

187. Multi-disciplinary care is one of the focuses in delivering PHC services and management of chronic diseases. Healthcare professionals, including doctors, CMPs, dentists, nurses, different allied health professionals such as PTs, occupational therapists (OTs), speech therapists, podiatrists, dietitians, as well as social workers, all have their distinctive roles in achieving co-ordinated, family-centric and community-based PHC services. The Government sees the need to further develop and unleash the potential of these professionals in supporting the development of PHC in Hong Kong.

188. To address the training and development needs of PHC professionals, **the Government proposes to enhance PHC training for all PHC service providers and to set training requirements under the PCR, to facilitate healthcare related professionals in both the public and private sectors to play a more active role in the development of PHC under a team approach and operate in a co-ordinated fashion as part and parcel of the district-based community health system.**

189. **To further strengthen the training on PHC, as stated in Recommendation 5.1, the Government have invited the Boards and Councils of various healthcare professions to review and consider how to increase the weighting of PHC elements in the context of their regular review of accredited training programmes.** As for practicing professionals (regardless of working in the PHC sector or not), building on the development in **paragraph 176**, the Government shall continue to work with different academic/training institutions to provide PHC related training for professional members of the multi-disciplinary PHC team. We will continue to evaluate and refine the training courses and explore the opportunity to work with different academic/training institutions to design PHC training for different healthcare and related professionals in support of PHC development in Hong Kong.

190. Upon the establishment of the Primary Healthcare Commission, **the Government also proposes to look into the co-ordination of training in different healthcare settings and developing a structured rotation system** to facilitate the training of family doctors and other PHC professionals in different training settings in a co-ordinated manner. We will also look into ways to construct a clearer professional development and career pathway and relevant incentives to attract healthcare professionals in pursuing a career in PHC.

RECOMMENDATION 5.3

Enhance the role of Chinese Medicine Practitioners and Chinese medicine in the primary healthcare services

191. Being an integral part of Hong Kong's healthcare system, CM plays an important role in the area of PHC to safeguard public health and well-being in concerted efforts with the other healthcare professions. In fact, the Government has all along

been promoting the development of CM in Hong Kong, and reaffirmed in the 2018 Policy Address the positioning of CM in the development of healthcare services in Hong Kong. Specifically, the Government subsidises a series of defined CM services to provide a comprehensive network for the delivery of government-subsidised CM services. Besides, in view of the relatively adequate and stable supply of CMP manpower in Hong Kong and the fact that over 90% of CM services are provided in the private market, the role of CM in PHC setting could be further explored with a view to fully utilising and unleashing the potential of the resources concentrated in the CM private market.

192. During the COVID-19 pandemic, with the support and facilitation of HHB, in relation to PHC services, HA launched a special CM out-patient programme to provide CM general consultation out-patient rehabilitation services to COVID-19 infected patients who have been discharged from public hospitals and persons who have completed isolation, through the 18 CMCTRs. Furthermore, CMPs in private practice also play an instrumental role in safeguarding public health during the pandemic by providing professional CM support and treatment to the public and taking their own initiatives to offer telemedicine and related services.

193. Considering the need to mobilise the resources of CM sector in the private market in our fight against the COVID-19 pandemic, HHB also rolled out a special support scheme through the Chinese Medicine Development Fund (CMDF) to subsidise CMPs to provide free telemedicine service and delivery service of CM to those infected with COVID-19 and staying at home. Recently, another special programme, which is also funded by CMDF, has been launched to provide free CM rehabilitation consultations and treatments to citizens that suffered from sequelae of COVID-19.

194. Having regard to the severe impact of the fifth wave of the epidemic on elderly persons at residential care homes for the elderly (RCHEs), under the support by HHB, the HA speedily took the lead in mobilising CMPs to participate in a special CM programme through community CM service providers such as universities, CM sector, CMP academic associations and NGOs, etc., to provide telemedicine or outreach CM services to infected residents and staff of RCHEs. The service concerned has subsequently been further expanded to cover CM rehabilitation consultations, such that recovered RCHE residents can receive treatment at the RCHE without travelling.

195. The experience of using CM in the fight against COVID-19 has clearly demonstrated the strengths and advantages of CM in PHC setting and beyond. **In the long term, as CM constitutes an integral part of Hong Kong's healthcare system, with a view to better leveraging on the strengths and advantages of CM, the Government will continue to strengthen the role of CM in PHC services, enhance multi-disciplinary collaboration, and look into opportunities for further synergies with CM in PHC settings with a focus on chronic disease prevention and health management through promotion, health assessment, preventive care and introduction of new programmes with the involvement of CM. Relevant training programmes should also be devised for CMPs to foster mutual understanding of the PHC services provided by different healthcare professionals.**

RECOMMENDATION 5.4
Enhance the role of allied health professionals and community pharmacists in the primary healthcare workforce

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

197. 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.

198. Furthermore, to ensure the professional competency of healthcare personnel, we will legislate to make continuing professional education and/or CPD 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 any statutory registration requirements such as clinical psychologists, speech therapists and dietitians, with a view to protecting public interest.

Primary Care Register

199. As recommended in **paragraph 125**, the Government proposes to develop sub-directories under the PCR for PTs, OTs and pharmacist in view of their extensive involvement in PHC for various medical conditions, in particular chronic illnesses and for long-term care. Sub-directories for other healthcare professionals (e.g. optometrists, nurses, speech therapists, dietitians, and other professionals who are not subject to any statutory registration requirements) shall also be developed in a later phase.

200. The inclusion of additional professions in the PCR shall help nurture a team approach and allow inter-disciplinary co-operation and cross-referral in a transparent, reliant manner. In addition, the quality of allied health professionals shall be assured through the enrolment and maintenance requirement imposed under the PCR.

Community Pharmacy

201. Pharmacists are becoming important providers of a wide range of healthcare services in the community to meet the needs of an ageing population and increasing number of people living with long-term health conditions. With active involvement of pharmacists, community pharmacy services also play an important role in PHC. Currently, pharmacists in DHCs are responsible for providing medication consultation to clients in order to maximise the benefit of drug treatment, reduce reliance and lower risk in the use of medicines. The pharmacists also work with other professionals of the multi-disciplinary team in health promotion and health education such as on medicine safety and smoking cessation.

202. During the COVID-19 pandemic, community pharmacies have offered to help refill HA patient prescriptions. To reduce the risk of infection and facilitate those patients under regular HA follow up who may not wish to visit HA's clinics during the epidemic, patients are given an option to refill their medication through community pharmacies either by in-person pickup or home delivery. These community pharmacies also provide counselling service for patients in need. As the above drug dispensing model matures, it is proposed to regularise such model so as to enable designated community pharmacies to dispense drugs and provide drug counselling services to HA patients, especially those with stable conditions, as an alternative to frequenting clinics for follow up visits.

Table 5.3

Proposed Further Development of Community Pharmacy Services
• To recruit community pharmacists as part of the DHC network
• To strengthen pharmacists' role by including them as part of the multi-disciplinary team in the care protocols of DHC's structured chronic disease management programmes with a view to providing medication advice and counselling for DHC members, in particular those with polypharmacy, taking specific drugs (e.g. warfarin), newly diagnosed of diabetes mellitus /hypertension, discharged from hospital or having recent change of medication regime
• To utilise network community pharmacists in providing smoking cessation service for the public
• To provide other health promotion/disease prevention services as appropriate
• To further explore the role of community pharmacists in drug refill and related counselling in support of the public health system

203. To support the development of community pharmacy in Hong Kong, HHB has set up a Working Group on Community Pharmacy to advise on the following:

(a) development of community pharmacy services as steered by the SCPHD;

(b) enhancing training for pharmacists to support development of PHC; and

(c) defining the qualifications/training and work experience required for pharmacists to support programmes conducted by DHCs.

204. Against the above background, the Government proposes to enhance the role of community pharmacies, including supporting patients on monitoring of drug compliance, dispensing drugs to HA patients and patients joining the CDCC Scheme with a pre-defined community drug formulary.

205. Among others, drug costs have a significant contribution to healthcare expenditures, yet massive discrepancies in prices appear between different forms of drug purchases: between generic and patented drugs, and newly researched and older drugs [22]. The high recurrent drug expenditures for managing chronic diseases is one of the major factors driving patients to use public services. Alongside the CDCC Scheme, it is recommended to set up a community drug formulary composing mainly of generic drugs and selected patented drugs under which patients from the community could enjoy drugs at lower prices while receiving services from purchased primary care programmes in the private sector through the CDCC Scheme (see also **Chapter 4-Recommendation 4.3**).

CHAPTER 5 - REINFORCE PRIMARY HEALTHCARE MANPOWER: ACTION PLAN

	Action		Short	Medium	Long
5.1	**PHC Manpower Supply**	• To increase UGC-funded and subsidised healthcare training places	■		
		• To invite Boards and Councils to increase the weighting of primary healthcare in their accreditation and placement programme		■	
		• To attract qualified non-locally trained PHC professionals to practise in Hong Kong	■		
		• To reflect and refine the PHC manpower projection for healthcare professionals	■	■	■
5.2	**PHC Training**	• To continue to work with different institutions to provide PHC-related training courses	■		
		• To strengthen professional training for family doctors, nurses, allied health professionals and social workers in PHC setting		■	
		• To establish a structured rotation system to facilitate the training of PHC professionals in different training settings in a co-ordinated manner		■	■
5.3	**CMPs**	• To strengthen the role of CM in PHC settings	■	■	■
		• To look into opportunities for further synergies with a focus on chronic disease prevention and health management	■	■	■
		• To devise training programme for CMPs on PHC		■	
5.4	**Allied Health Professionals and Community Pharmacists**	• To amend relevant Ordinances to allow patients' direct access to certain healthcare professional services (e.g. physiotherapy and occupational therapy) under specific circumstances, without a doctor's referral	■		
		• To support the development of community pharmacy in Hong Kong under the advice of the Working Group on Community Pharmacy	■		
		• To designate community pharmacies to dispense drugs	■	■	
		• To engage community pharmacies to support the CDCC Scheme	■	■	

CHAPTER

IMPROVE DATA CONNECTIVITY AND HEALTH SURVEILLANCE

An effectively connected digital healthcare data network for immediate access and sharing of health records among patients and healthcare service providers in the public and private sectors 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. For policy planning and resource allocation in the district-based community health system, particularly for evidence-based strategic purchasing, data collection on healthcare costs (including manpower and financial costs), health seeking behaviours, as well as district-based health information and providers' performance are to be enhanced.

206. A comprehensive and co-ordinated PHC system for enhancing patients' continuous care can be underpinned by an effectively connected patient data network which provides a robust and secure infrastructure for access and sharing of patients' health records by healthcare service providers in the public and private sectors. For individuals, patients' care needs can be fulfilled more timely, effectively and in an integrated manner by multi-disciplinary teams from different sectors. For the community, it facilitates medical-social collaboration, promotes inter-sectoral and multi-disciplinary partnership, and encourages the use of more agile and innovative approaches in providing healthcare services in order to optimise the use of healthcare resources.

207. At the territory-wide level, patient data would even contribute to health surveillance and facilitate an on-going, systematic collection, analysis and interpretation of health related information for the planning, implementation and evaluation of public health practices. It is necessary for early identification of public health emergencies, monitoring the epidemiology of health condition, monitoring the progress and evaluating the impact of public health intervention, and guiding public health policy and strategies.

208. In particular, the COVID-19 epidemic has demonstrated the significance of strong information flow and revealed the importance of an interconnected data system and healthcare database as the backbone of health policy planning, preparedness and response. At the same time,

the pandemic enabled innovations in PHC being advanced and propagated, such as telemedicine, online scheduling and prescriptions along with strengthened health information system capacity.

Electronic Health Record Sharing System (eHealth)

209. The eHealth is an electronic platform developed by the Government that enables registered healthcare providers in both the public and private sectors, with the informed consent of the registered patient and proper authorisation, to view and share the patient's electronic health records. The eHealth aims to encourage PPP and facilitate continuity of care as patients move between the public and private healthcare systems. We have also been strongly encouraging members of the public to join the eHealth for building their lifelong electronic health records.

210. HA has been the Government's technical agency for the development and operation of the eHealth. To facilitate private healthcare professionals to participate in the eHealth and data uploading, clinical management software and technical support have been provided. These include the Clinical Management System (CMS) adaptation modules for private hospitals to connect to and interface with the eHealth, and the CMS On-ramp, a clinical management software with sharing capability and turn-key system readily usable by private clinics.

211. In response to the epidemic, we have incorporated the eHealth registration procedure to the booking and vaccination process of the COVID-19 Vaccination Programme. As at early September 2022, over 5.6 million people (over 70% of the population of Hong Kong) have voluntarily registered to join the eHealth, bringing new opportunities to the future development of the system.

eHealth App

212. The eHealth mobile application ("eHealth App") developed by the Government is the mobile application of the eHealth. Launched in January 2021, it is positioned as the public health portal of Hong Kong for promoting PHC development and encouraging the public to more proactively manage their health. The "eHealth App" will disseminate personalised public health information to users and users can also access some of their key electronic health records in public and private healthcare organisations, including vaccination records, medication, appointments, allergies and adverse drug reactions.

213. To encourage members of the public to proactively and systematically manage and monitor their health using the eHealth App, the eHealth App has added new functions at the end of July 2021, allowing users to record their daily blood pressure and blood sugar index, which can facilitate the monitoring of changes in their physical conditions. The users can also show the indices to healthcare professionals for reference during check-ups to reduce consultation times. The GOPC PPP of HA and DHCs, which are being gradually set up in various districts, also encourage and assist patients who have joined the relevant schemes to use the eHealth App, with a view to further increasing their awareness in disease prevention, assisting them to record their blood pressure and blood sugar index, as well as enhancing their ability to manage their own health in order to tie in with the Government's PHC policies and reinforce that "prevention is better than cure". As at early September 2022, over 2.6 million people had downloaded the eHealth App.

"HA Go"

214. "HA Go", the mobile application developed by HA, aims to help patients manage their medical appointments and healthcare arrangement in the HA system. "HA Go" integrates multiple applications of HA and adds new functions, including checking appointment record, making out-patient appointment, mobile payment, checking medication information, and carrying out rehabilitation exercise in accordance with prescription, etc. As at end of March 2022, over one million people have used multiple HA services through "HA Go".

215. "HA Go" and "eHealth App" encourage and facilitate the public to proactively manage their health at different levels. We will further study how to leverage on the strengths of the two mobile applications to optimise and rationalise the related functions.

Health Surveys

216. Health-related data are also available from various health surveys, such as DH's Population Health Survey (PHS), Health Behaviour Survey and Oral Health Survey (OHS). Social and demographic data are provided through the Population Census and other regular household surveys conducted by the Census and Statistics Department (C&SD).

217. The PHS is a cross-sectional survey targeted at the land-based non-institutional population aged 15 or above in Hong Kong, excluding visitors, foreign domestic helpers and Two-way Permit holders from Mainland China. The sample was drawn from a record of all addresses in built-up areas and non-built-up areas (known as the Frame of Quarters) maintained by C&SD. The survey comprises two parts, namely household interview and health examination.

Table 6.1

Population Health Survey	
Household Interview and self-administered questionnaire	• Physical and psychosocial health status • Health-related lifestyle practices • Preventive health practices • Household information
Health Examination	• Physical measurements - Blood pressure - Body Height and Weight - Waist and hip circumference • Biochemical tests - Lipid profile - HbA1C and fasting plasma glucose - Iron status - Viral hepatitis - Urine test for iodine, sodium, potassium and creatinine

218. The PHS was first conducted in 2003-04, with the last round conducted in 2014-15. DH commenced the territory-wide PHS 2020 in November 2020 to update pertinent information on the patterns of health status, health-related lifestyles and other health parameters of the local population.

219. The PHS 2020 will continue to adopt a comprehensive approach that contains elements of previous surveys. The PHS 2020 is part of the Government's commitment to the Partnership for Healthy Cities, a global network of 70 cities committed to saving lives by preventing NCDs (i.e. chronic diseases) and injuries.

220. The first community-wide OHS was conducted in 2001 and DH undertook to carry out an OHS every 10 years. The OHS 2011 was therefore conducted to collect information on oral health status of the people of Hong Kong. The OHS 2021 was commenced in November 2021. The OHS 2021 targets five population groups, namely five-year-old children, 12-year-old youths, adults aged between 35 and 44, elderly aged 65 to 74 and elderly aged 65 and over who are receiving long-term care services. Oral health goals for people of different age groups in Hong Kong will be set by making reference to the results of the OHS 2021. DH will also explore ways to improve dental care services and recommend possible measures for achieving the goals.

Health Technology and COVID-19

221. COVID-19 has accelerated the development and utilisation of health technologies which are used to help fill gaps in service delivery and in complementarity with in-person services. During the COVID-19 pandemic, the Government has utilised the existing eHealth platform and further enhanced the application of medical technology to help improve the capability in combating the epidemic, as summarised in Table 6.2.

Table 6.2

eHealth MEASURE UNDER COVID-19	
Online platform for private doctors to order COVID-19 oral drugs	• Private doctors who have registered under the eHealth are provided with a dedicated electronic platform to enable them to make requests for the two antiviral drugs, Paxlovid and Molnupiravir, for COVID-19 patients • Private doctors may log in at the platform to make the requests, and the order will be distributed to their selected practice address among those they have registered with the eHealth. The distributor will process the requests as far as possible on the following working day. A maximum of 10 standard courses of treatments for each antiviral is allowed on each order request • Guidelines, fact sheets on the use of the drugs as well as other points to note provided by HA are available for download at the ordering pages of the platform
Telemedicine pilot programme under "HA Go"	• COVID-19 patients in the community may make appointments for designated clinic/ tele-consultation service through "HA Go" • Add-on functions are introduced to support specified groups of patients to receive tele-consultation services • Patients may choose to receive their service either in-person or through the tele-consultation functions of HA Go
COVID-19 vaccination record under eHealth App	• The public can store and display their COVID-19 vaccination records and medical exemption certificate and the related QR codes for facilitating the Vaccine Pass arrangement.
"Fight the Virus Together – Chinese Medicine Telemedicine Scheme"	• HHB, through the Chinese Medicine Development Fund and co-ordinated by the Federation of the Hong Kong Chinese Medicine Practitioners and Chinese Medicines Traders Association, launched a special support scheme to subsidise Chinese medicine practitioners to provide free Chinese Medicine (CM) telemedicine services as well as dispensing and delivery of CM drug to relevant patients.

THE CHALLENGES

222. Without a multi-functional one-stop healthcare electronic platform to facilitate the Government in population health management through analysing the big data, healthcare policy and strategies could not be determined in a precise and an evidence-based manner. In this regard, we will continue to enhance and expand the functions of the eHealth App with a view to making its use more prevalent for serving as the public health portal of Hong Kong.

223. Meanwhile, health-related data, including population health status, health-related lifestyles, other health parameters and socio-demographic data, are now collected through various health surveys. For policy planning and resource allocation of the PHC, particularly for evidence-based strategic purchasing, data collection on healthcare costs (including manpower and financial costs), health seeking behaviours, district-based health information and providers' performance is also to be enhanced.

OUR AIM

224. The utilisation of health data to help optimise healthcare services and promote medical innovation is an important development direction of Hong Kong's healthcare policy. **With eHealth being the backbone to underpin the gate-keeping and referral mechanism proposed in the Blueprint for enhancing care co-ordination and health surveillance, we aim to optimise the use of the health information and data of DH, HA and DHCs**

under one platform for formulating protocols for disease surveillance, screening, prevention and treatment.

225. To improve data connectivity and health surveillance, we propose the following –

RECOMMENDATION 6.1

Enhance the eHealth as the gate-keeping and referral tool for care co-ordination and health surveillance

226. Launched in 2016, the eHealth is developed to serve as the backbone IT infrastructure to enable PPP, which alleviates the burden on the public health system, and makes better use of our precious medical resources by avoiding duplication of medical assessments and treatment, and improve the continuity, efficiency and quality of care as patients move between various healthcare providers in the public and private health sectors.

227. Currently, the eHealth supports various PPPs of HA, DHCs, as well as some of DH's PPP initiatives, such as the Colorectal Cancer Screening Programme. The one-stop CM clinical record system "EC Connect" has also been launched to enable the access and sharing of relevant clinical records by phases through the eHealth platform for the CM sector. **We propose to transform the eHealth from a health record sharing system into a comprehensive and integrated underpinning information infrastructure for healthcare data sharing, service delivery and process management especially PHC-related services**, with multiple function layers to facilitate service record keeping, essential data sharing (such as allergies history, 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.

228. Meanwhile, **we recommend to mandate the use of eHealth and the uploading of key health data for all PHC healthcare professionals listed on the PCR and participating in the subsidised Government health programmes as mentioned in** Recommendation 3.2, including DHs' VSS, the EHCV Scheme and CDCC Scheme. Under this proposal, participating healthcare providers will be required to upload the health data and information of the relevant patients, before moving further beyond. The ultimate goal is for useful health records and data of our citizens in the public and private healthcare systems as well as different levels of the medical system to be collected in the eHealth. At the same time, it is envisaged that the eHealth would be transformed into an integrated system with multiple function layers to facilitate record keeping, diagnosis, monitoring, triage, referral and payment, with big data analytics contributing to population health surveillance. In the long run, it shall be developed into the healthcare database of Hong Kong, with one single, composite eHealth account for each healthcare provider and each citizen. Public health initiatives can be more readily promoted, co-ordinated and monitored under one centralised IT platform.

229. Some of the detailed suggested enhancement measures of eHealth are listed in Table 6.3 below.

Table 6.3

eHealth ENHANCEMENT MEASURES	
Migration of eHealth System (Subsidies) to the eHealth	• Developed in 2008, the eHealth System (Subsidies) (eHS(S)) serves as the administrative and record keeping system for the Elderly Health Care Vouchers (EHCV) Scheme and Vaccination Subsidy Scheme (VSS). For the EHCV, it provides the platform for healthcare service providers to manage the eHealth accounts for the elderly and handle reimbursements. As for the VSS, it stores the reimbursement records of vaccinations administered under different programmes and the vaccination records of the territory-wide COVID-19 Vaccination Programme • Following system migration, data from eHS(S), including reimbursement records/ vaccination records and voucher usage, etc., would become part and parcel of the eHealth central data repository and may be used and shared via the existing eHealth channels connecting the different sectors and tiers of the healthcare system, subject to the parameters for data sharing under the prevailing governance of the eHealth
Integration of Primary Care Directory (PCD)	• As discussed at Recommendation 3.2, the PCD is a web-based electronic database containing practice information and professional qualifications of primary care providers in the community. In support of the long term development of primary healthcare at the community level, the policy direction is now to redefine the role of the PCD into a Primary Care Register (PCR) which could serve as a central register for all primary healthcare professionals under one umbrella for better monitoring, co-ordination and quality assurance • It is proposed that the PCR be linked up and integrated with the eHealth public interface in order to provide a one-stop platform for users to access information on the PCR
Integration of all public-private partnership (PPP) programmes & SPPs under the eHealth platform	• The migration and integration of various systems to the eHealth platform, together with the eHealth's existing linkages with PPP programmes and future SPPs, will help provide a common platform for programme enrollment, user account management, service monitoring, financial reimbursement and auditing, etc.

230. As regards data upload from the private sector, the current situation is far from satisfactory and without a much-improved scale of upload by healthcare providers, the full potential of the eHealth cannot be actualised. Other than mandating the use of the eHealth for all participants of Government-subsidised health programmes, **we will work towards implementing a one-off funding programme that targets facilitating connectivity of clinical management systems by private eHealth solution vendors, with a view to making data upload more palatable and convenient for private healthcare providers.**

231. In the longer run, we recommend **to require all PHC service providers to use eHealth and input the medical data, essential health and service data of service users into the eHealth account of the service users**, with a view to strengthening the protection for healthcare service users, ensuring healthcare quality and raising standards, and enhancing co-ordinaton and continuity in the healthcare process, especially in the PHC at the community level and referral to and from the public hospital system, through mandates by necessary amendments to the Electronic Health Record Sharing System Ordinance (Cap. 625) and inclusion of relevant requirements in PCR and SPPs.

RECOMMENDATION 6.2
Promulgation of the eHealth App as the lifelong personal electronic health account

232. Health data collected under the eHealth platform unlocks the potential for developing patient empowerment functions aimed at serving the specific needs of individual users. For example, push notifications through the eHealth App can be initiated for a targeted age group or demographic, to remind breast cancer screening for females in a certain age bracket or recall for cervical re-screening to facilitate continuity of care. Self-input of relevant personal health information may facilitate on-going management and monitoring of chronic diseases. The eHealth App can also act as the technology platform for self-health management campaigns such as smart eating. In addition, community carers can make use of telecare facilitation to stay connected with their patients. For example, the provision of online exercise or rehabilitation training delivered through an internet platform for DHC or SPPs may be paired with the eHealth App.

233. Leveraging on the robust infrastructure of the eHealth as the backbone and the vibrant IT sector, our vision on the eHealth App is to promote it as a lifelong and indispensable personal electronic health record sharing system/account to facilitate the traversing of patients across the different sectors and tiers of the healthcare system. **Through self-input and retrieval of key health data provided by their family doctors on the eHealth App, users will be able to participate in their own health management, improve their health literacy and be empowered to manage their own health especially if they have chronic diseases**. The ultimate goal is to leverage on the eHealth and its reach to the wider community to bolster the Government's efforts in building a PHC-centric system.

234. We are also contemplating to develop an eHealth ecosystem which enables the connectivity of the eHealth App with other third-party electronic health apps (such as apps for exercise challenge) or wearables to encourage wider usage. **To complement the policy direction of development of PHC with focus on prevention, we will continue to enhance the eHealth App to serve as the individualised health management tool.**

235. In addition, the Government will continue to actively allocate resources to drive medical technology innovation with a view to further enhancing healthcare efficiency and enabling sustainable development of healthcare services.

RECOMMENDATION 6.3
Support policy planning with data

236. In the area of healthcare data and technological application, HA's Big Data Analytics Platform has supported multiple big data and artificial intelligence research projects since its establishment. The research areas include improving PHC services, risk forecast for various chronic diseases, timely prevention of deterioration, etc. Currently, HA has applied artificial intelligence to improve services in different aspects, including introducing artificial intelligence to analyse chest X-ray at all A&E departments in hospitals and GOPCs, in order to assist doctors to screen out patients with lung disease and high risk as soon as possible; using big data to identify patients with higher risks of diabetes, to provide personalised care planning for chronic disease, intervene early and raise the self-management ability of patients, etc. HA will continue to conduct research and introduce more healthcare-related artificial intelligence technology with a view to broadening the application to healthcare services and bringing greater benefits to patients in the long term.

237. Aside from boosting the impact of the eHealth, in broader terms, we believe that it is important for us to consider how to make better use of survey results and the patient/user health records from DH, HA, the eHealth and DHCs to facilitate overall health surveillance. The Government proposes to provide forecast and projection on the population health profile to facilitate evidence-based PHC policy making and programme planning. For instance, it would be useful to explore whether

data available on the HA's Big Data Analytics Platform may be further utilised to provide forecast and projection on the population health profile. In addition, with the territory-wide launch of DHCs, the data collected from DHCs will also facilitate on-going health monitoring and projection.

238. 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 the 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, PHC 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 will take up and review the next PHS. The Office should also more effectively promote big data applications and monitor the progress and evaluate the impact of public health interventions to provide guidance on public health policy and strategies.

CHAPTER 6 - IMPROVE DATA CONNECTIVITY AND HEALTH SURVEILLANCE: ACTION PLAN					
		Action	Short	Medium	Long
6.1	**eHealth**	• To extend mandatory use of the eHealth to all subsidised Government health programmes			
		• To put in place incentive programmes that facilitate connectivity by private eHealth solution vendors			
		• To integrate various standalone public health IT systems/modules under the eHealth platform			
		• To require private medical labs and radiology centres to join and upload lab images to the eHealth			
		• To transform the eHealth into an integrated system – "One eHealth"			
		• To explore the wider use of eHealth as a platform for outside entities			
		• To consider mandating the use of eHealth through amending the Electronic Health Record Sharing System Ordinance (Cap. 625)			
		• To continue to develop and enhance the one-stop CM clinical record system EC Connect			
6.2	**eHealth App**	• To enable the connectivity of eHRSS/eHealth App with other third-party electronic health apps or wearables			
		• To facilitate tele-medicine and connection to other health technology for patients and health professionals			
6.3	**Research and Data Analytics**	• To transform the existing Research Office into a dedicated Research and Data Analytics Office under HHB			
		• To develop a population-based health dataset			
		• To set up a mechanism including tools and indicators to measure outcomes as listed in the Blueprint			
		• To review the next PHS			
		• To monitor the progress and evaluate the impact of public health interventions including recommendations in this Blueprint			

CHAPTER

7 A SUCCESSFUL PRIMARY HEALTHCARE SYSTEM

239. The COVID-19 pandemic has presented exceptional challenges to public health system around the world. Hong Kong is no exception. To maintain the remarkable efficiency, professionalism and high adaptability of the healthcare system in Hong Kong, we need to make continuous improvements in multiple aspects in order to tackle the challenges posed to our healthcare services by an ageing population and the epidemic.

240. The COVID-19 pandemic has further highlighted the critical importance of a strong district-based PHC system. This Blueprint sets out our vision and outlines the specific recommendations and implementation plans to lay down a strategic roadmap for the future development of PHC in Hong Kong.

241. The successful development of PHC 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 in Recommendation 6.3 shall develop relevant mechanism (including tools and indicators) to measure the outcomes in the following areas –**

HEALTHCARE SERVICE PROVISION

- Increased coverage of preventive care for all, particularly for the target groups such as the low income and underprivileged groups
- More vertically and horizontally integrated healthcare
- Improved quality in PHC services
- Improved patients' care experience and carers' experiences
- Decreased waiting time for public specialist care
- Decreased utilisation of acute care and inpatient care
- Decreased age- and co-morbidity- adjusted hospital admissions and average length of stay

HEALTHCARE EXPENDITURE

- Increased expenditure on PHC as a proportion of current health expenditure
- Increased public health expenditure on PHC provided by the private sector
- Decreased age- and co-morbidity-adjusted costs (in terms of manpower and expenditure) per healthcare case

HEALTH EMPOWERMENT AND WELLBEING

- Improved health literacy
- Increased proportion of patients who have a family doctor or a case manager
- Decreased risk factors for health
- Decreased prevalence of age-adjusted chronic diseases
- Decreased prevalence of chronic disease-related complications
- Improved age- and co-morbidity- adjusted health status
- Improved quality of life of patients and carers

242. In accordance with the Blueprint recommendations, we expect to take forward various 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 strategic purchasing, policy making, performance management and improvement of PHC services in Hong Kong.

SUMMARY TABLE OF ACTIONS

CHAPTER 2 – DEVELOP A COMMUNITY-BASED PRIMARY HEALTHCARE SYSTEM: ACTION PLAN					
	Action		Short	Medium	Long
2.1	**DHCs**	• To set up 7 DHCs and 11 DHC Expresses			
		• To set up 18 DHCs across the territory			
		• To review the DHC service model			
	Migration of PHC Services	• To migrate public PHC services from DH			
		• To migrate PHC services (e.g. patient empowerment, community support, etc.) from HA			
		• To enhance collaboration between DHC and DECCs/NECs			
2.2	**“Chronic Disease Co-Care Scheme” (CDCC Scheme)**	• To review the Sham Shui Po DHC Pilot Programme for chronic disease management upon completion of pilot programme			
		• Upon review of the Pilot Scheme, to gradually expand the CDCC Scheme to all HT and DM patients in Hong Kong			
		• To review the CDCC Scheme and explore possible expansion			
2.3	**Review of-GOPCs’ positioning**	• To divert GOPCs’ non-target group patients with HT and/or DM to receive subsidised treatment provided by private sector via CDCC Scheme			

CHAPTER 3 - STRENGTHEN PRIMARY HEALTHCARE GOVERNANCE: ACTION PLAN					
	Action		Short	Medium	Long
3.1	**Primary Healthcare Commission**	• To expand PHO's establishment by introducing regional governance structure	■		
		• To expand PHO by leveraging on the existing manpower from DH and HA	■	■	
		• To establish the Primary Healthcare Commission with new legislation to provide the mandate and statutory powers for the Primary Healthcare Commission to implement the standards on private PHC service providers	■	■	
3.2	**Primary Care Directory**	• To develop sub-directories for pharmacists and other health professionals in the Primary Care Directory (PCD)	■	■	
		• To review the enrolment or maintenance requirement for the PCD	■		
		• To require healthcare practitioners joining subsidizedsubsidised programmes to register in PCD	■		
		• To establish the Primary Care Register (PCR), with the support of eHealth and legal backing by relevant ordinance		■	
	Reference Frameworks in Primary Care Setting	• To develop and expand the applicability of the Reference Framework (RFs) to various disease groups and to explore the involvement of CM in the RFs	■	■	■
		• To establish the RFs, with the support of eHealth backed by the Primary Healthcare Commission as the standard of care protocol for PCR healthcare practitioners		■	
3.3	**Primary-secondary referral mechanism**	• To devise the primary-secondary referral mechanism based on the existing referral system in the public health system	■	■	■
		• To promulgate relevant referral mechanism for the CDCC Scheme	■		
		• To implement the referral mechanism with the support of eHealth and backing by Primary Healthcare Commission in the public and private sectors		■	

CHAPTER 4 - CONSOLIDATE PRIMARY HEALTHCARE RESOURCES: ACTION PLAN					
	Action		Short	Medium	Long
4.1	CDCC Scheme	• To conduct market research and programme design for the CDCC Scheme	■		
		• To review the positioning and interfacing of the GOPC PPP and the CDCC Scheme in terms of pricing, drug list, subsidisable conditions and referral criteria, etc.	■		
		• To transition the GOPC PPP to CDCC Scheme	■	■	
		• To conduct ongoing review and evaluation on the CDCC Scheme	■	■	■
4.2	EHCV	• To review the applicability of ECHVs for other PHC programmes besides DHC	■		
		• To designate a certain amount of Elderly Health Care Voucher for preferred use related to PHC purposes and self-registered family doctors	■	■	
4.3	Strategic Purchasing Office	• To set up the Strategic Purchasing Office (SPO) by integrating the existing Health Care Voucher Division of DH and Service Transformation Department (PPP office) of HA	■		
		• To oversee the development and implementation of PHC programmes under strategic purchasing	■		
		• To conduct ongoing review and evaluation on the SPPs		■	■
		• To explore enhancing Chinese medicine PHC services by resource allocation through strategic purchasing		■	■
		• To set up the community drug formulary to support patients	■	■	■
4.4	Land Resources	• To set up a centalised inventory of healthcare facilities to identify and project supply-demand gap of land resources for PHC services	■		
		• To explore room to consolidate and co-locate health service facilities especially those relating to PHC services	■	■	
		• To devise a policy for land premium concession by non-profit making organisations delivering PHC services	■		
		• To explore providing space for PHC facilities for the use of healthcare operators (including those to be operated by NGOs) under relevant policies		■	

CHAPTER 5 - REINFORCE PRIMARY HEALTHCARE MANPOWER: ACTION PLAN

	Action		Short	Medium	Long
5.1	**PHC Manpower Supply**	• To increase UGC-funded and subsidised healthcare training places	■		
		• To invite Boards and Councils to increase the weighting of primary healthcare in their accreditation and placement programme		■	
		• To attract qualified non-locally trained PHC professionals to practise in Hong Kong	■		
		• To reflect and refine the PHC manpower projection for healthcare professionals	■	■	■
5.2	**PHC Training**	• To continue to work with different institutions to provide PHC-related training courses	■		
		• To strengthen professional training for family doctors, nurses, allied health professionals and social workers in PHC setting		■	
		• To establish a structured rotation system to facilitate the training of PHC professionals in different training settings in a co-ordinated manner		■	■
5.3	**CMPs**	• To strengthen the role of CM in PHC settings	■	■	■
		• To look into opportunities for further synergies with a focus on chronic disease prevention and health management	■	■	■
		• To devise training programme for CMPs on PHC		■	
5.4	**Allied Health Professionals and Community Pharmacists**	• To amend relevant Ordinances to allow patients' direct access to certain healthcare professional services (e.g. physiotherapy and occupational therapy) under specific circumstances, without a doctor's referral	■		
		• To support the development of community pharmacy in Hong Kong under the advice of the Working Group on Community Pharmacy	■		
		• To designate community pharmacies to dispense drugs	■	■	
		• To engage community pharmacies to support the CDCC Scheme	■	■	

SUMMARY TABLE OF ACTIONS

CHAPTER 6 - IMPROVE DATA CONNECTIVITY AND HEALTH SURVEILLANCE: ACTION PLAN					
	Action		Short	Medium	Long
6.1	**eHealth**	• To extend mandatory use of the eHealth to all subsidised Government health programmes	✓		
		• To put in place incentive programmes that facilitate connectivity by private eHealth solution vendors	✓		
		• To integrate various standalone public health IT systems/modules under the eHealth platform		✓	
		• To require private medical labs and radiology centres to join and upload lab images to the eHealth		✓	
		• To transform the eHealth into an integrated system – "One eHealth"			✓
		• To explore the wider use of eHealth as a platform for outside entities			✓
		• To consider mandating the use of eHealth through amending the Electronic Health Record Sharing System Ordinance (Cap. 625)		✓	
		• To continue to develop and enhance the one-stop CM clinical record system EC Connect	✓		
6.2	**eHealth App**	• To enable the connectivity of eHRSS/eHealth App with other third-party electronic health apps or wearables	✓		
		• To facilitate tele-medicine and connection to other health technology for patients and health professionals		✓	
6.3	**Research and Data Analytics**	• To transform the existing Research Office into a dedicated Research and Data Analytics Office under HHB	✓		
		• To develop a population-based health dataset	✓		
		• To set up a mechanism including tools and indicators to measure outcomes as listed in the Blueprint	✓		
		• To review the next PHS	✓	✓	
		• To monitor the progress and evaluate the impact of public health interventions including recommendations in this Blueprint		✓	✓

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LIST OF ABBREVIATIONS

A&E	Accident and Emergency
C&SD	Census and Statistics Department
CDCC Scheme	Chronic Disease Co-Care Scheme
CHCs	Community Health Centres
CKD	Chronic Kidney Disease
CM	Chinese Medicine
CMDF	Chinese Medicine Development Fund
CMCTRs	Chinese Medicine Clinics cum Training and Research Centres
CME	Continuing Medical Education
CMH	Chinese Medicine Hospital
CMPs	Chinese Medicine Practitioners
CMS	Clinical Management System
CNS	Community Nursing Services
COHK	The College of Ophthalmologists of Hong Kong
COVID-19	Coronavirus Disease 2019
CPD	Continuing Professional Development
CVD	Cardiovascular Disease
DCHK	The Dental Council of Hong Kong
DECCs	District Elderly Community Centres
DH	The Department of Health
DHA	Domestic Health Accounts
DHC	District Health Centre
DM	Diabetes Mellitus
EHCs	Elderly Health Centres
EHCV	Elderly Health Care Voucher
eHealth	Electronic Health Record Sharing System
eHealth App	eHealth Mobile Application
eHS(S)	eHealth System (Subsidies)
FHB	Food and Health Bureau (re-organised as Health Bureau with effect from 1 July 2022)
FMSC	Family Medicine Specialist Clinic
GOPCs	General Out-patient Clinics
GOPC PPP	General Out-patient Clinic Public-Private Partnership Programme
GPs	General Practitioners
HA	The Hospital Authority
HHB	Health Bureau
HKAM	The Hong Kong Academy of Medicine
HKAN	The Hong Kong Academy of Nursing
HKCFP	The Hong Kong College of Family Physicians
HKOTA	Hong Kong Occupational Therapy Association
HT	Hypertension
LWB	Labour and Welfare Bureau
MCHCs	Maternal and Child Health Centres
MCHK	The Medical Council of Hong Kong
MED	Medicine specialty
NAHCs	Nurse and Allied Health Clinics

NCDs	Non-communicable Diseases
NECs	Neighbourhood Elderly Centres
NGOs	Non-governmental Organisations
O&T	Orthopaedics & Traumatology specialty
OHS	Oral Health Survey
OT	Occupational Therapist
PCD	Primary Care Directory
PCO	Primary Care Office
PCR	Primary Care Register
PEP	Patient Empowerment Programme
PHC	Primary Healthcare
PHFs	Private Healthcare Facilities
PHO	Primary Healthcare Office
PHS	Population Health Survey
PolyU	The Hong Kong Polytechnic University
PPP	Public-Private Partnership
PSY	Psychiatry
PT	Physiotherapists
RAMP	Risk Factor Assessment and Management Programme
RCHEs	Residential Care Homes for the Elderly
RFs	Reference Frameworks
SAP	Towards 2025: Strategy and Action Plan to Prevent and Control Non-communicable Diseases in Hong Kong
SCPHD	Steering Committee on Primary Healthcare Development
SOPC	Specialist Out-patient Clinic
SPO	Strategic Purchasing Office
SPPs	Strategic Purchasing Programmes
SWD	Social Welfare Department
The Blueprint	Blueprint for the Sustainable Development of Primary Healthcare Services for Hong Kong
The Strategy Document	Primary Care Development in Hong Kong: Strategy Document
UGC	University Grants Committee
VHTs	Visiting Health Teams
VSS	Vaccination Subsidy Scheme
WHCs	Woman Health Centres
WHO	World Health Organization

GLOSSARY OF TERMS

Allied health professionals Health professionals that are not part of the medical, dental or nursing professions. They have specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses.
In Hong Kong, allied health professionals include audiologists, clinical psychologists, dietitians, occupational therapists, optometrists, orthoptists, physiotherapists, podiatrists, prosthetists and orthotists, speech therapists, dispensers, radiographers, medical laboratory technologists and medical social workers.

Care co-ordination A proactive approach that brings care professionals and providers together around the needs of service users to ensure that people receive integrated and person-focused care across various settings.

Carers Individuals who provide care for a member or members of their family, friends or community. They may provide regular, occasional or routine care or be involved in organising care delivered by others. Carers are in contrast with providers associated with a formal service delivery system, whether paid or on a volunteer basis.

Case management A targeted, community-based and proactive approach to care that involves case-finding, assessment, care planning and care co-ordination to integrate services around the needs of people with a high level of risk requiring complex care (often from multiple providers or locations), people who are vulnerable, or people who have complex social and health needs. The case manager co-ordinates patient care throughout the entire continuum of care.

Chronic disease A disease that is long-lasting or recurrent, and with slow progression. Examples of chronic diseases include diabetes mellitus and hypertension.
(also known as non-communicable diseases)

Communicable diseases Diseases that can be transmitted directly or indirectly from one person to another. Examples include influenza, tuberculosis, dengue fever and hepatitis B.

Community A unit of population, defined by a shared characteristic (for example, geography, interest, belief, or social characteristic), that is the locus of basic political and social responsibility and in which every day social interactions involving all or most of the spectrum of life activities of the people within it takes place.

Community engagement A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes.

Continuity of care The degree to which a series of discrete health care events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences.

Continuum of care The spectrum of personal and population health care needed throughout all stages of a condition, injury, or event throughout a lifetime, including health promotion, disease prevention, diagnosis, treatment, rehabilitation, and palliative care.

Core primary healthcare team in a DHC Team members include chief care co-ordinator, care co-ordinators, dietitian, pharmacist, physiotherapist, occupational therapist and social worker.

Cost-effectiveness The minimal expenditure of financial and other resources necessary to achieve the appropriate healthcare result. It is a ratio of costs to the valued health care outputs (for example, outcomes) produced.

Curative care Healthcare services that are concerned with treatment of acute episodic illness and injury.

Disease management A system of co-ordinated, proactive health care interventions of proven benefit and communications to populations and individuals with established health conditions, including methods to improve people's self-care efforts.

Disease surveillance Disease surveillance is the systematic collection, analysis and dissemination of data on diseases of public health importance so that appropriate action can be taken to either prevent or stop further spread of disease. It guides disease control activities and measures the impact of immunisation services.

District health system According to WHO, it is a self-contained segment of the national health system. It includes all the relevant healthcare activities in the area, whether governmental or otherwise. It includes self-care and all public healthcare personnel and facilities, whether governmental or non-governmental, up to and including the hospital at the first referral level and the appropriate support services (e.g. laboratory, diagnostic and logistic support). It will be most effective if it is co-ordinated by an appropriately trained district health management team, working to ensure as comprehensive a range as possible of promotive, preventive, curative and rehabilitative health activities. Its components include district health office, district hospital or hospitals, health centres, community, neighbourhood and households, private health sector, non-governmental organisations and mission health services.

Doctor-shopping Refers to patients going to numerous different doctors to seek investigation

and treatment for the same health conditions.

Domestic Health Accounts (of Hong Kong) A set of descriptive account that traces all the financial resources that flow through Hong Kong's health system over time. It is compiled according to the International Classification for Health Accounts Framework developed by Organisation for Economic Co-operation and Development (OECD) to describe systematically the totality of health expenditure flows in both government and non-government sectors.

Effectiveness The extent to which a specific intervention, procedure, regimen or service does what it is intended to do for a specified population when deployed in everyday circumstances.

Efficiency The ratio between health system inputs (e.g. costs, in the forms of labour, capital, or equipment) and either outputs (e.g. number of patients treated) or health outcomes (e.g. life years gained).

Empowerment The process of supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours or an increase in the ability to self-manage illnesses.

Engagement The process of involving people and communities in the design, planning and delivery of health services, thereby enabling them to make choices about care and treatment options or to participate in strategic decision-making on how health resources should be spent.

Essential public health functions The spectrum of competences and actions that are required to reach the central objective of public health - improving the health of populations. It includes health protection, health promotion, disease prevention, surveillance and response, and emergency preparedness.

Evaluation A process that systematically and objectively assesses the relevance, effectiveness and impact of activities in the light of their objectives and the resources deployed. Several varieties of evaluation can be distinguished, such as evaluation of structure, process and outcome.

Family doctor A personal doctor, who can be a general practitioner, a family medicine specialist or any other specialist, provides comprehensive and continuing primary care to every patient and refers patient to other healthcare services when necessary.

In Hong Kong, it often refers to the major primary care service provider (such as general practitioner, family medicine specialist or primary care specialist) who provides comprehensive, family-centric, continuing, preventive and co-ordinated care in the community.

Family medicine The medical specialty that provides continuing and comprehensive healthcare for the individual and family irrespective of age, gender and illness. The core role of family medicine is in the provision of primary care, that is, in promoting health, preventing disease and providing curative or palliative care to patients

in the community.

Family practice (or general practice) The discipline for the provision of comprehensive and continuing healthcare to individuals in the context of their family and community. Its scope encompasses all ages and both sexes. Providers often include generalist practitioners or family medicine doctors, physician's assistants, family nurses, and other healthcare professionals.

First level of care The entry point into the health care system at the interface between services and community.

Fragmentation (of health services) The lack of co-ordination among healthcare services in different platforms of care; and/or the lack of continuity of healthcare services over time.

Gate-keeping The processes by which primary care authorises access to specialty care, hospital care, and diagnostic tests, for example through required referral.

General Practitioner (GP) A licensed medical practitioner who provides personal, primary, and continuing comprehensive healthcare for any health problems of individuals and families. In Hong Kong, it refers to medical practitioner in general practice or family practice.

Governance An overarching healthcare systems function and also applies to specific healthcare financing aspects such as purchasing to ensure that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability. It also refers to exercising authority, setting roles and responsibilities and shaping the interactions of the various healthcare actors, i.e. purchasers, providers, provider associations, society and beneficiaries.

Health surveillance The continuous and systematic collection, orderly consolidation and evaluation of pertinent data with prompt dissemination of results to those who need to know, particularly those who are in a position to take action.

Health system It consists of all organisations, people, and institutions producing actions whose primary intent is to promote, restore, or maintain health.

Healthcare pathway (or clinical pathway) A structured multi-disciplinary management plan (in addition to clinical guideline) that maps the route of care through the healthcare system for individuals with specific clinical problems.

Healthcare service Any service (not limited to medical or clinical services) aimed at contributing to improved health or to the diagnosis, treatment and rehabilitation of individuals and populations.

Healthcare system performance The degree to which a healthcare system carries out its functions of governing, financing, resourcing and delivering services, to achieve its goals.

Healthcare accessibility The ability, or perceived ability, to reach healthcare services or healthcare facilities in terms of location, timeliness and ease of approach.

Healthcare affordability (a) The ratio of the expenditure to a household's total resources; or (b) a household's residual income after the expenditure.

Healthcare professionals In Hong Kong, they include medical practitioners, Chinese medicine practitioners, dentists, dental hygienists, pharmacists, nurses, midwives, medical laboratory technologists, occupational therapists, optometrists, radiographers, physiotherapists and chiropractors.

Healthcare strategic purchasing The transfer of revenues to providers based on information on either the health needs of the population served and/or the performance of the providers. It is the active use of purchasing functions, tools and levers by a health financing agency to achieve the strategic objectives set for the health purchaser(s) to contribute the wider health system objectives.

Health-seeking behaviour Any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy.

Holistic care Care that considers the whole person, including psychological, social and environmental factors, rather than just the symptoms of disease or ill health.

Horizontal integration Co-ordination, collaboration, joint planning and shared activity among healthcare service providers at the same stage of service production process across all settings to ensure consistent and comprehensive care over time. The co-ordination and collaboration among the healthcare and social services in public and private sectors in primary healthcare is an example of such integration.

Indicator Explicitly defined and measurable metric that helps in the assessment of the structure, process or outcomes of an action or a set of actions.

Inputs Any resources that are used in the production of healthcare outputs and/or outcomes. They may include monetary or physical resources (for example, capital, labour, drugs) but also could include healthcare activities (for example, diagnostic tests or surgical procedures) if they are conceptualised as resources used to combine a more aggregate health care output.

Integrated healthcare services The management and delivery of healthcare services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services through the different functions, activities and sites of care within the healthcare system.

Life-course approach An approach suggesting that the health outcomes of individuals and the community depend on the interaction of multiple protective and risk factors throughout people's lives. This approach provides a comprehensive vision of health and its determinants, which calls for the development of healthcare services centred on the needs of its users at each stage of their lives.

Life expectancy at birth Average number of years that a newborn is expected to live if current mortality rates continue to apply.

Multi-disciplinary teams Various healthcare professionals working together to provide a broad range of services in a co-ordinated approach. The composition of multi-disciplinary teams in primary care will vary by setting but may include generalist medical practitioners, physicians assistants, nurses, specialist nurses, community health workers, pharmacists, social workers, dieticians, mental health counsellors, physiotherapists, patient educators, managers, support staff, and other primary care specialists.

Multi-sectoral action on health Policy design, policy implementation and other actions related to health and other sectors (for example, social protection, housing, education, agriculture, finance and industry) carried out collaboratively or alone, which address social, economic and environmental determinants of health and associated commercial factors or improve health and well-being.

Out-of-pocket payments Expenditures paid directly by individuals for healthcare services at the point of use. It often refers to user fees or co-payments.

Outputs Units of activity produced by combining healthcare inputs. They may include healthcare activities, such as surgical procedures (which are produced through combinations of labour, capital and other resources), or physical outputs, such as episodes of care (which are produced through combinations of healthcare activities).

Population health An approach to healthcare that seeks to improve the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Preventive care The routine health care, including vaccinations, health checks, screenings and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary healthcare vs Primary care "Primary healthcare" is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and preferences and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment.
"Primary healthcare" encompasses primary care. Primary care is the more visible and service-oriented core of primary healthcare.

Primary prevention Actions aimed at avoiding the manifestation of a disease (this may include actions to improve health through changing the impact of social and economic determinants on health; the provision of information on behavioural and medical health risks, alongside consultation and measures to decrease them at the personal and community level; nutritional and food supplementation; oral and dental hygiene education; and clinical preventive services such as immunisation and vaccination of children, adults and the elderly, as well as vaccination or post-exposure prophylaxis for people exposed to a communicable disease).

Private health expenditure Health expenditure financed by the private sector (e.g. employer-provided medical benefits, private health insurance, and private household out-of-pocket expenditure).

Public health expenditure Health expenditure financed by the public sector (e.g. the Government, and statutory organisations managing social health insurance).

Public-private partnership (PPP) A business relationship between the public and private sectors whereby there is a contractual arrangement in which the private partner participates to fund and deliver public services, and shares certain risks.

Purchaser (or purchasing agency) An agency that purchases healthcare services on behalf of its members or a specific population on group from pooled funds.

Referral The direction of an individual to the appropriate facility or practitioner in a healthcare system or network of service providers to address the relevant health needs.

Responsiveness The ability of the health system to meet the population's legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth.

Safety net (in Hong Kong) It safeguards and promotes the general public health of the community as a whole and to ensure the provision of medical and health facilities for the people of Hong Kong, including the provision of public assistance to help a person meet his or her basic and special medical needs in cases where he or she does not have the means to access them as well as to protect him or her from undue financial burden.

Secondary care The medical care that is provided by specialist or facility upon referral by a primary care practitioner and that requires more specialised knowledge, skill, or equipment than the primary care practitioner can provide.
In Hong Kong, secondary care services include acute and convalescent in-patient care, day surgery, specialist out-patient, and Accident and Emergency services.

Secondary prevention Healthcare activities that aim at early detection of disease, thereby increasing opportunities for interventions to prevent progression of the disease. Measures include health check-ups and disease screening, followed by necessary interventions after making the diagnosis.

Self-care Individuals, families and communities are supported and empowered to appropriately manage their health and well-being when not in direct contact with healthcare services.

Self-management of health The knowledge, skills and confidence to manage one's own health, to care for a specific condition, to know when to seek professional care, or to recover from an episode of ill-health.

Stewardship A responsibility for the effective planning and management of health resources to safeguard equity, population health and well-being.

Tertiary care It refers to highly complex and costly hospital care, usually with the application of advanced technology and multi-disciplinary specialised expertise. Examples of tertiary care services include organ transplants.

Tertiary prevention It refers to the rehabilitation of patients with an established disease to minimise residual disabilities and complications and maximise potential years of enjoyable life, thereby improving the quality of life even if the disease itself cannot be cured. Tertiary prevention programmes include patient empowerment and support, chronic disease management and community rehabilitation programmes.

Triage The sorting out and classification of casualties to determine the priority of need and proper place of treatment.

Vertical integration The co-ordination of the functions, activities or operational units that are in different phases of healthcare service production process. This type of integration includes the links between platforms of healthcare service delivery, for example between primary care and hospitals.

Voucher A kind of coupon with a prescribed purchasing power, over a specified service.

Well-being A multi-dimensional construct aiming at capturing a positive life experience, frequently equated to quality of life and life satisfaction. Measures of well-being typically focus on patient-reported outcomes covering a wide range of domains, such as happiness, positive emotions, engagement, meaning, purpose, vitality and calmness.

APPENDIX A – HONG KONG'S CURRENT HEALTHCARE SYSTEM

A.1
Hong Kong's public and private medical sectors provide comprehensive healthcare services, including a low-cost public healthcare safety net that ensures no one in Hong Kong is denied medical care due to lack of means.

A.2
The Health Bureau (HHB) formulates policies and allocates resources for healthcare services, with the aim of protecting and promoting public health, providing lifelong holistic care to every resident and ensuring no one is denied medical help due to lack of means.

A.3
The Department of Health (DH) is the public health authority and executes policies and statutory functions. It safeguards the community's health through promotional, preventive, curative and rehabilitative services.

A.4
The Hospital Authority (HA) provides public hospital and related services. It offers medical treatment and rehabilitation services through hospitals, SOPCs, GOPCs, CMCTRs, and community outreach services.

A.5
The Primary Healthcare Office (PHO) was established on 1 March 2019 directly under HHB to oversee and steer the development of PHC services at the bureau level. PHO focuses on the development of DHCs as a new model leveraging on public-private partnership and medical-social collaboration to cater for the needs and characteristics of the districts and enhance public awareness of healthy living, disease prevention and self-management of health. It has also been tasked to spearhead the overall review and future development of PHC services.

Health figures at a Glance

Infant mortality rate	2020	2 per 1 000 registered live births	
Maternal mortality ratio	2020	0 per 100 000 registered live births	
Life expectancy at birth	2021	83.2 (Male)	87.9 (Female)
	2069 (projected)	88.4 (Male)	93.9 (Female)

A.6
Hong Kong has an excellent healthcare system supported by a highly professional team of workers. The infant mortality rate in 2020 was among the lowest in the world. Male and female life expectancy at birth was among the world's highest in 2021.

A.7
Hong Kong's Domestic Health Accounts show total health expenditure increased from 3.6% to 6.7% of GDP from 1989/90 to 2019/20. Over the same period, public health expenditure ($101.5 billion in 2019/20, or 3.6% of GDP) rose from 40% to 54% of total health expenditure. The Government's recurrent funding for health has risen by about 63% over the past five years, from $58.7 billion in 2016 to $95.9 billion in 2021. Year-on-year, the recurrent funding for health grew more than 10% from $87.1 billion in 2020. It accounted for 19% of the Government's recurrent expenditure in 2021.

HEALTHCARE SERVICE PROVISION

Primary Healthcare

A.8
PHC is the first step in the healthcare process. It covers a wide range of services, including health promotion and disease prevention, general out-patient and allied health services, and special services for people in specific age groups who do not need immediate hospital attention.

A.9
General out-patient and allied health services are provided mainly by the private sector and NGOs. In 2020/21, private Western clinics handled more than 18 million out-patient visits. NGOs operate community clinics, and many also organise health promotions and educational activities. Some NGOs provide health assessments for the elderly and medical check-ups for women.

A.10
The public sector provides PHC services mainly through the DH, the HA and DHCs. PHC is being delivered using a life course approach through the DH's various areas of work with emphasis on preventive care. The HA operates 73 GOPCs, including 3 CHCs, used mainly by the elderly, low-income families and chronic disease patients. In 2021, some 1.7 million people used these services, with 6.3 million attendances recorded.

District Health Centres

A.11
To enhance district-based PHC, HHB aims to set up DHCs in all 18 districts. Each DHC is operated by an NGO with government funding to promote medical-social collaboration, public-private partnership and district-based services. It focuses on primary, secondary and tertiary prevention, including health promotion, health assessment, screening and managing chronic diseases, and community rehabilitation.

A.12
Following the commencement of operation of Kwai Tsing, Sham Shui Po, Tuen Mun, Wong Tai Sin, Southern and Yuen Long DHCs, DHC in Tsuen Wan district will also commence operation in 2022. Smaller-scale interim "DHC Expresses" have been established in the other 11 districts since September 2021.

PREVENTIVE CARE

A.13
The DH provides health promotion and disease prevention services to the community particularly for infants, children, women and the elderly through the following services.

Family Health

A.14
There are 31 Maternal and Child Health Centres and three Woman Health Centres that provide immunisation, parenting, health and developmental surveillance, and breastfeeding support for children from birth to five years of age and women aged 64 or below. Antenatal, postnatal, family planning and cervical screening services and health education are also offered for women. Some 16,000 expectant mothers and 35,000 newborn babies attended such centres in 2021.

Student Health

A.15
There are 13 Student Health Service Centres and four Special Assessment Centres that provide health screening and individual counselling to primary and secondary students. Eight school dental clinics provide preventive dental services, including annual check-ups and basic care. At special schools, students with disabilities can use these services until age 18. In 2020-21, about 336,700 or 94 per cent of all primary students participated in such services. At special schools, students with disabilities can use these services until age 18.

Elderly Health

A.16
Eighteen Elderly Health Centres provide PHC to people aged 65 and above, including assessment, treatment, education and counselling, and 18 VHTs which promote health activities for the elderly and provide training to carers. In 2021, there were about 38,000 enrolments and 133,000 attendances for health assessment and medical consultation, as well as some 280,000 attendances at promotional activities organised by the Elderly Health Service.

A.17
The EHCV Scheme subsidises the elderly to receive private primary care in the community that best suits their needs. The annual voucher amount for each eligible person is $2,000, with a maximum accumulation limit of $8,000. The government keeps the scope and utilisation of the scheme under review to strengthen its effectiveness and enhance primary, especially preventive, care for the elderly.

Vaccination

A.18
The Hong Kong Childhood Immunisation Programme protects children against vaccine-preventable diseases such as tuberculosis, hepatitis B, poliomyelitis, tetanus, pertussis, measles, diphtheria, mumps, rubella, chickenpox, pneumococcal disease and human papillomavirus (for school girls of suitable grades). Pertussis vaccinations are provided for women between 26 and 34 weeks of pregnancy, as part of routine antenatal care at maternal and child health centres.

A.19
The Government Vaccination Programme and the Vaccination Subsidy Scheme provide free or subsidised seasonal influenza vaccinations respectively from October each year to eligible people, including children and those aged 50 or above. The vaccinations are provided through kindergartens and child care centres, primary and secondary schools, public hospitals and clinics, residential care homes for the elderly and for persons with disabilities, residential child care centres, and designated institutions serving people with intellectual disabilities. Starting from November 2022, the scope of eligible groups under various seasonal influenza vaccination programmes has been expanded to cover those aged less than 18 (or secondary school students).

Cancer Screening Programmes

A.20
The government provides screening for cervical cancer, colorectal cancer and breast cancer. The Cervical Screening Programme encourages women aged between 25 and 64 who ever had sex to undergo regular screening while the Colorectal Cancer Screening Programme subsidises asymptomatic residents aged between 50 and 75 to undergo screening. From September 2021, the Breast Cancer Screening Pilot Programme has provided screening services for eligible women, aiming to detect breast cancer before symptoms appear so that early treatment can be carried out.

Community Outreach Healthcare

A.21
Community outreach healthcare aims to reduce reliance on inpatient services and help patients recover in the community. In 2021, the Hospital Authority conducted 2.01 million home visits and outreach care services for, among others, the elderly and people with mental illness. Around 85% of those receiving the HA's community nursing services are elderly. Community geriatric assessment teams visit residential care homes for the elderly regularly to provide medical and nursing care to frail residents who are unable to attend SOPCs. These teams also train carers at the homes to care for their residents. Patient Support Call Centre provides support to high-risk elderly patients discharged from public hospitals, offering advice on disease management and care support, and arranging referrals to appropriate services for patients in need.

Oral Health

A.22
The Government's policy on dental care seeks to improve oral health and prevent dental diseases by raising public awareness of oral health and encouraging improved habits through promotion and education. Educational activities include the Brighter Smiles for the New Generation for pre-school children and the Bright Smiles Mobile Classroom for primary students, while the annual Love Teeth Campaign encourages good dental habits. Eleven government dental clinics provide emergency services in pain relief and tooth extraction, while six public hospitals offer specialist oral health care services. The Government also monitors the level of fluoridation in public drinking water to reduce dental decay.

A.23
Under the Outreach Dental Care Programme for the Elderly, teams set up by NGOs receive government subsidies and provide free on-site oral check-ups for elderly people and oral care training to caregivers in residential care homes, day care centres and similar facilities. Free dental treatment will be provided on-site or at a dental clinic if necessary. The Healthy Teeth Collaboration programme provides free oral check-ups, dental treatment and oral health education for adults with intellectual disabilities aged 18 or above through NGO dental clinics. The Special Oral Care Service provides dental service for pre-school children under six years old with intellectual disabilities at the Hong Kong Children's Hospital, and provides on-site dental check-ups and oral health education for eligible children at special child care centres.

MENTAL HEALTH

A.24
The government adopts an integrated approach in promoting mental health, encompassing prevention, early identification, timely intervention and rehabilitation. Cross sectoral and multidisciplinary support and care services are available through collaboration among government bodies and other relevant organisations including the Health Bureau, Labour and Welfare Bureau, Education Bureau, Hospital Authority, Social Welfare Department and Department of Health.

A.25
The Hospital Authority is a major medical service provider for people with mental disorders. Its psychiatric services include inpatient facilities, day hospitals, specialist outpatient clinics and community outreach. In 2020-21, about 275,800 people received treatment and support through these services. In 2021-22, the authority has earmarked additional funding of around $156 million to address the escalating demand for psychiatric services.

A.26
The Advisory Committee on Mental Health advises the government on mental health policies and follows up on recommendations in the Mental Health Review Report. In March 2021, the committee initiated a pilot scheme to provide timely assessment, intervention and support to children and adolescents with mental health needs through medical-social collaboration.

A.27
In September 2021, the committee began the second phase of the mental health promotion and public education initiative 'Shall We Talk'. Over 855 organisations signed the Mental Health Workplace Charter that aims to promote a mental health friendly workplace, benefiting more than 510,000 employees. To address the impact of the COVID-19 epidemic on public mental health, the government earmarked $300 million for the committee to launch the Mental Health Initiatives Funding Scheme.

SECONDARY, TERTIARY AND SPECIALISED HEALTHCARE

A.28
These services are available mainly in the HA's hospitals and SOPCs. As at end-2021, the city had 30

[1] Consisting of all beds in the HA's hospitals, private hospitals, nursing homes and correctional institutions.

105 public hospital beds, comprising 23 774 general beds, 1 981 infirmary beds, 3 675 beds for the mentally ill and 675 for the mentally disabled. There were also 5 050 private hospital beds, comprising 4 682 inpatient beds and 368 day beds; 6 465 beds in nursing homes and 874 in institutions run by the Correctional Services Department. There were 5.6[1] beds per 1 000 population. Public hospitals spent $52.8 billion on inpatient services in 2020/21 and discharged 1.81 million inpatients and day inpatients in 2021.

A.29
The HA's SOPCs arrange appointments for new patients based on the urgency of their clinical conditions, to ensure those with acute conditions receive priority. Patients in stable condition are referred to family medicine and GOPCs, or to primary care practitioners in the private sector for follow-up. In 2021, the HA's SOPCs recorded 8.19 million attendances.

A.30
In 2019/20, spending on both public and private inpatient and specialist out-patient services totalled about $96.9 billion, of which 73% was spent on the public sector. In 2020/21, the HA's specialist clinics spent about $14.9 billion on providing medical services.

Allied Health Services

A.31
Allied health professionals working under the HA include audiologists, clinical psychologists, dietitians, OTs, optometrists, orthoptists, PTs, podiatrists, prosthetists and orthotists, speech therapists and medical social workers. They provide rehabilitative and extended care to help patients receiving inpatient, out-patient, ambulatory and community care services to reintegrate into society. In 2021, the authority's allied health outpatient departments recorded 3.08 million attendances.

Accident and Emergency Services

A.32
Eighteen public hospitals provide accident and emergency services, delivering a high standard of service for critically ill or injured people and victims of disasters.

A.33
Patients are classified under five categories according to their clinical conditions: critical cases come under Category 1, emergency cases under Category 2, urgent cases under Category 3, semi-urgent cases under Category 4, and non-urgent cases under Category 5. The triage system ensures patients with more urgent needs receive prompt treatment. In 2021, all Category 1 patients received immediate treatment and over 95% of Category 2 patients were treated within 15 minutes.

A.34
These services spent some $4.3 billion in 2020/21 and handled 1.87 million visits by 1.14 million people in 2021, an average of about 5 100 attendances per day.

Other Special Services

A.35
Specialist facilities under the DH include 19 methadone clinics, 17 chest clinics, eight social hygiene clinics, four dermatological clinics, one integrated treatment centre, four centres and clinics providing services related to clinical genetics, seven child assessment centres and two travel health centres. These facilities recorded around 2.1 million attendances in 2021.

Medical Charges and Waivers

A.36
Fees for public hospital and clinic services are government-subsidised at a rate of 97.3%. Under a medical fee waiver mechanism, the HA grants waivers to needy groups including CSSA recipients, low-income patients, Higher Old Age Living Allowance (including Guangdong and Fujian

scheme) recipients aged 75 or above, the chronically ill and elderly patients with financial difficulties.

Private Hospitals

A.37
Private hospitals complement the public sector by providing a range of specialist and hospital services. The 13 private hospitals, including one commissioned in 2021, providing 5 050 hospital beds as at end-2021. The private hospitals served 276 723 inpatients in 2020, representing 15% of the city's total number of inpatients. Spending on private inpatient services amounted to $26.5 billion in 2019/20, accounting for 36% of overall expenditure on public and private inpatient services.

Public-private Partnership (PPP) Programmes

A.38
The Government takes part in clinical PPP programmes through the HA. Services include cataract surgery, haemodialysis, radiological investigation, colon assessment, glaucoma treatment, trauma operation and breast cancer surgery. The HA's GOPC PPP Programme subsidises clinically stable patients with HT and/or DM under the care of its GOPCs to opt for primary care from the private sector. A Co-care Service Model, developed in late 2021, enables clinically stable patients under the HA's SOPCs to receive healthcare from the private sector.

Voluntary Health Insurance Scheme

A.39
Voluntary Health Insurance Scheme aims to regulate the quality of individual indemnity hospital insurance products and improve market transparency, providing consumers with greater confidence in purchasing health insurance and private healthcare services, thereby alleviating pressure on the public healthcare system. As of end-2021, the number of scheme policies reached 980,000.

CHINESE MEDICINE

Flagship Infrastructure

A.40
The Government is constructing the first Chinese medicine hospital in Hong Kong, promoting service development, education and training, innovation and research. In June 2021, the Government announced that Hong Kong Baptist University (HKBU) would be the contractor of the hospital's operation. The hospital is expected to begin services, in phases, from 2025.

A.41
The Government Chinese Medicines Testing Institute specialises in testing and scientific research of Chinese medicines aiming to set internationally recognised standards. The temporary institute began operating in 2017 and publishes research results on the Chinese Medicine Regulatory Office website. The construction of the permanent institute began in June 2021 and is expected to be commissioned in 2025.

Services

A.42
At the district level, the 18 CMCTRs promote the development of Chinese medicine through services, training and research, under a collaboration model involving the HA, NGOs and local universities. The Government provides an annual quota of around 620 000 subsidised Chinese medicine out-patient attendances, covering general consultation, acupuncture and bone setting/tui na services. There were about 1.28 million attendances in 2021.

A.43
The HA implements the Integrated Chinese-Western Medicine Programme at designated public hospitals to gain experience in providing Chinese medicine inpatient services in stroke care, musculoskeletal pain management and cancer palliative care. The number of participating hospitals increased to eight in April, covering all seven of the authority's hospital clusters. The number of participating hospitals has increased to eight, covering all seven of the authority's hospital clusters.

A.44
Private Chinese medicine clinics record about 9 million attendances each year

Development Initiatives

A.45
The $500 million Chinese Medicine Development Fund provides subsidies which benefit numerous segments of the sector, including training in Chinese medicine, enhancing manufacturing practices for proprietary Chinese medicines, improving clinic facilities and supporting scientific research and promotional activities. The then Food and Health Bureau launched a review on the overall implementation of the fund in 2021.

A.46
In August 2021, streamlined approval procedures allowing Hong Kong registered proprietary Chinese medicines for external use to be registered and sold in the Guangdong-Hong Kong-Macao Greater Bay Area (GBA) and an arrangement for selected public healthcare institutions in the GBA to recruit Hong Kong Chinese medicine practitioners were implemented.

DISEASE PREVENTION AND CONTROL

A.47
The Centre for Health Protection under the DH works with local and international counterparts to prevent and control diseases in Hong Kong. It works on three principles: real-time surveillance, rapid intervention and responsive risk communication. The Centre keeps track of communicable diseases and issues surveillance reports and laboratory data reports regularly.

Prevention and Control of Infectious Diseases

A.48
The Prevention and Control of Disease Ordinance specifies 51 statutory notifiable infectious diseases in Hong Kong. The Centre continually reviews and updates its strategies for coping with major outbreaks of infectious diseases, including an influenza pandemic, the Ebola virus disease, measles, Middle East Respiratory Syndrome, Zika virus infection and dengue fever, ensuring both the government and the community are prepared to deal with them.

A.49
To prevent and control the cross-boundary spread of infectious and other serious diseases into or out of Hong Kong, the DH's Port Health Division enforces health quarantine measures according to the International Health Regulations and the Prevention and Control of Disease Ordinance.

Prevention and Control of Non-communicable Diseases

A.50
Non-communicable diseases including cancer, cardiovascular diseases, chronic respiratory diseases and DM together accounted for about 55% of all registered deaths in 2020.

A.51
The Government is implementing 'Towards 2025: Strategy and Action Plan to Prevent and Control Non-communicable Diseases in Hong Kong', which sets out nine targets to be achieved by 2025 and a portfolio of initiatives to reduce the burden of non-communicable diseases.

A.52
The Hong Kong Cancer Strategy aims to reduce the cancer burden in the local population and improve the quality of life and survivorship of cancer patients. The Government promotes as the primary preventive strategy the adoption of a healthy lifestyle, which includes no smoking, avoiding alcohol consumption, eating a balanced diet and engaging in regular physical activity.

A.53
The Department of Health is also coordinating the implementation of two other action plans, which set out strategies and priorities to eliminate the health threats posed by antimicrobial resistance and viral hepatitis.

HEALTH PROMOTION

A.54
The DH's Health Promotion Branch (HPB) formulates and implements strategies and measures to promote healthy eating, regular physical activity and mental wellness to target groups at different settings. The HPB also updates information and health advice on infectious diseases and produces materials in various languages to raise awareness among ethnic minorities of how to prevent communicable diseases and adopt a healthy lifestyle.

A.55
The DH works closely with Healthy Cities projects, NGOs and other community partners and solicits their support to carry out health promotion activities, disseminate health information, alert the public to health threats and facilitate implementation of preventive measures.

APPENDIX B –
PRIMARY HEALTHCARE SYSTEM IN SELECTED PLACES

Global Megatrends on PHC Development

B.1
Over the decades after the *Declaration of Alma-Ata* in 1978, people are healthier, wealthier and living longer. However, new challenges such as globalisation, ageing population and urbanisation have made health systems in the world difficult to meet the increasing healthcare demands and changing healthcare needs. Besides, in many countries, healthcare is still disease-focused, treatment-focused, fragmented and inefficient in service delivery, and the opportunity to work across sectors and programmes, and involve the community in healthcare decision-making is often overlooked. The concept of PHC has also been repeatedly reinterpreted and redefined, leading to confusion about the term and its practice. In view of this, WHO proposed reforms for health systems to improve health equity, make health systems people-oriented, promote and protect the health of communities, and make health authorities more reliable in *World Health Report 2008: Primary Health Care: Now More Than Ever* in 2008. In 2018, WHO reviewed the lessons learned over the decades and recapped the components of PHC in *A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable*.

B.2
In the 40th anniversary of the 1978 Declaration, policy makers and health experts met in Astana and developed the Declaration of Astana on Primary Health Care in 2018. The countries re-affirmed the commitments of health for all and the importance of strengthening PHC for it, and committed to engage multi-sectoral involvement in PHC; strengthen PHC system with policies, investment, knowledge, human resources, technology and financing; empower individuals and communities in health management; and align the supports and joint efforts of the stakeholders.

B.3
For effective implementation of PHC, WHO has also promoted district health system since 1980s. District health system is defined as a self-contained segment of the national health system which includes all the relevant healthcare activities and healthcare services in the area, whether governmental or non-governmental. It will be most effective if it is co-ordinated by an appropriately trained district health management team, provides as comprehensive as possible a range of promotive, preventive, curative and rehabilitative health services. Its components include district health office, district hospital or hospitals, health centres, community, neighbourhoods and households, private health sector, NGOs and mission health services.[2] In 1995, WHO reviewed the experiences of district health system and identified the critical areas for the success of PHC strategy at the district level, including: organisation, planning, and management; finance and resource allocation; information; community involvement in health; intersectoral action; capacity building; institutional strengthening of health centres and district hospital; urban district health systems; and quality assurance.[3]

B.4
COVID-19 pandemic has added to the challenges of chronic disease burdens and the risk factors from ageing population, healthcare accessibility and rising healthcare costs. It is shown that countries with strong PHC systems are more able to maintain access to essential healthcare services and minimise complications and death from COVID-19.

[2] Chatora, R., & Tumusiime, P. (2004). Health sector reform and district health systems.

[3] World Health Organisation (1995). District health systems : global and regional review based on experience in various countries.

Against this backdrop, the WHO Regional Office for the Western Pacific has developed a draft regional framework for PHC in April 2022.

B.5
The proposed strategic directions of the framework included:

(i) creating effective service delivery models appropriate for the local context, including through use of integrated service networks and multi-disciplinary care, empanelment, expansion of service packages, linkages with social welfare services, and leveraging digital technology;

(ii) creating a provider and healthcare worker base to align with the needs of communities through optimisation methods like task-shifting, workforce expansion and incentivisation, adapting recruitment, training and education, multi-disciplinary teams, and private sector engagement;

(iii) realigning PHC financing with health needs through purchasing reform and benefits design to incentivise primary care and population health, prioritising public financing of PHC and public health, and addressing bottlenecks in public finance management; and

(iv) building supportive enabling environments for PHC reform, through revising legal, policy and regulatory frameworks to support integrated and participatory services, strengthening health management and co-ordination, enhancing community participation, establishing monitoring mechanisms for learning and improvement, investing in PHC infrastructure, and facilitating the adoption of digital technology.[4]

B.6
For OECD countries, OECD examined PHC before and after the COVID-19 pandemic and has identified the key policy challenges and recommended changes in Realising the Potential of Primary Health Care published in 2020. The recommended changes included: new models of care in multiple professional team with the support of digital technology; more economic incentives to encourage teamwork, prevention-oriented and continuity of care; and giving boarder role to patients in management of their health with the support of digital tools. COVID-19 pandemic stimulates many innovative development in PHC, such as allowing community pharmacists to extend prescriptions and community health workers to provide COVID-19 information, developing telemedicine services, and providing add-on payments to enhance service delivery.

Selected International Practices on PHC

B.7
A brief introduction on the policy direction, governance, strategic purchasing, service delivery and financing of the PHC in the five selected places, namely, Mainland China, the United Kingdom, Singapore, Australia and New Zealand, is set out at pursuing paragraphs. **A table of comparison is also illustrated at Table B.1 below.**

[4] World Health Organization. (2022). Member State Consultation on the Regional Framework for Primary Health Care in the Western Pacific, Virtual, 26-27 April 2022: meeting report.

Table B.1:
Policy direction, governance, strategic purchasing, service delivery and financing of PHC services in the selected places

	MAINLAND CHINA	THE UNITED KINGDOM	SINGAPORE	AUSTRALIA	NEW ZEALAND
Health policy direction	• To develop a prevention-oriented, prevention-treatment integrated and Chinese-western medicine integrated healthcare system.	• Policy on wellbeing and health to help people live more independent, healthier lives for longer.	• Encourage people to take responsibility for their own health, and prepare health safety nets to ensure affordable healthcare for all.	• To co-ordinate care in local areas, with PHC as the first point of contact.	• Healthy futures for all New Zealanders – where people live longer and healthier lives.
Governance and strategic purchasing	• National Healthcare Commission (國家衛生健康委員會) formulates national healthcare policies and measures, and oversees and co-ordinates the implementation of the health strategies.	• The Department of Health & Social Care oversees the policies. • Quality assurance by Care Quality Commission. • Strategic purchasing by statutory Integrated Care Boards.	• The Ministry of Health oversees and regulates the healthcare system.	• Health Council as the overarching oversight body to shape health system and regulate service delivery of health professionals. • Strategic purchasing by Primary Health Networks (PHNs).	• Policy making, stewardship, regulation, performance assessment and funding allocation by the Ministry of Health. • Strategic purchasing in districts by Health New Zealand (Health NZ).
Service co-ordination, monitoring and clinical support in a district health system	• "Family Doctor Service Agreement (家庭醫生簽約服務)": multi-disciplinary and co-ordinated service package for each residents. • "Healthcare-in-Levels (分級診療)" policy: PHC as the first level of contact, to triage preventive and curative care, chronic and acute care and co-ordinate the different levels of healthcare. • Larger leading hospital supports PHC and other care units in the district to form a Healthcare Network (醫療聯合體).	• A wide range of medical services are brought together under National Health Services (NHS), with GP practice in primary care setting as the first point of contact. • Residents have to register a GP for NHS services. GP's referral is required for NHS specialist and hospital services. • Over 99% GPs provide subsidised services in a primary care network (PCN) with the lead of a clinical director.	• Close-to-home PHC services are provided through a network of 23 subsidised outpatient polyclinics and 1 800 private GP clinics. • Clinical support to community GPs and patients by PCNs and government primary care centres. • Regional healthcare cluster and Agency for Integrated Care support and co-ordinate healthcare and social services for integrated care • To gate-keep for A&E service, higher A&E fees and subsidy for A&E fees upon GP's referral.	• PHNs establish GP-led Clinical Councils and Community Advisory Committees to promote partnership building, capability building, and performance monitoring of PHC services. • Free government-funded GP helpline supported by nurse and GP for after-hours healthcare support. • The Government evaluates healthcare performance and reports it publicly.	• Health NZ funds Primary Health Organisations (PHOs) to provide PHC services and co-ordinate the subsidised health services. • PHOs bring together GPs and other healthcare professionals to provide services to their enrolled populations. • PHO's performance is evaluated and reported publicly.
Financing	• In the national health expenditure in 2021, 44.9% was **social health expenditure** (including social health insurance, enterprise financing/ insurance schemes and social institutions financing schemes), 27.4% was government health expenditure and 27.7% was individual's out-of-pocket expenditure.	• About 80% of health expenditure is funded by **taxation** from government to NHS, with smaller proportion from National Insurance Contribution and private payment.	• About half of health expenditure is funded by government, jointly from **taxation, mandatory health insurance (contributed from employer**s and employees) and **mandatory medical savings** (contributed from people's income). Government endowment fund MediFund provides a safety net.	• About 70% of health expenditure is funded by government, from **taxation**. • Most taxpayers pay a 2% income tax levy, and the higher income groups without private insurance cover pay extra 1% to 1.5% levy surcharge, for healthcare services at low cost or free under Medicare's insurance coverage.	• About 80% of total health expenditure is funded by government from **taxation**, with smaller proportion from out-of-pocket and private health insurance. • Over three-quarters of the public funds is allocated to districts, and 19% to important national health services.

Mainland China

B.8

The healthcare system of China is under rapid development in recent years, with emphasis on strengthening PHC system. In 2015, the State Council of China published *National Healthcare System Planning Outlines 2015-2020* 《全國醫療衛生服務體系規劃綱要(2015—2020年)》 comprehensively set out the vision and goals of national healthcare system planning with a view to improving healthcare resources allocation, service accessibility, capacity and efficiency, and guiding the implementation of district healthcare development regarding the organisation, resources allocation, infrastructure building, the roles and responsibilities definition of local governments and providers, quality assurance, monitoring and evaluation.[5] In 2016, the State Council published a healthcare policy paper *Healthy China 2030" Planning Outlines* 《健康中國2030規劃綱要》, launching the healthcare system development strategies in the later 15 years. The principles include to develop a prevention-oriented, prevention-treatment integrated and Chinese-western medicine integrated healthcare system.[6] In 2018, the State Council established National Healthcare Commission (國家衛生健康委員會) to formulate national healthcare policies and measures, and oversee and co-ordinate the implementation of the "Healthy China" strategies.[7] In 2019, a comprehensive action plan covering the actions towards public health education, healthy diet, physical exercise, tobacco control, mental health enhancement, environmental health, the health of women and children, the health of primary and secondary school students, occupational health protection, the health of elderly, cardiovascular diseases, cancer, chronic respiratory diseases, diabetes, infectious diseases and endemic diseases, as well as the supporting systems of management, monitoring and evaluation, supervision and assessment, technical support and publicity for "Healthy China 2030" was prepared.[8] In the same year, the Standing Committee of the National People's Congress passed the *National Basic Healthcare and Health Promotion Law* 《中華人民共和國基本醫療衛生與健康促進法》 to facilitate the healthcare and health system development, ensure basic healthcare service for citizens, improve citizens' health status, and advance the construction of "Healthy China".[9]

B.9

In regard to the prevention-oriented healthcare strategies, the "Healthcare-in-Levels (分級診療)" policy is proposed to emphasise community PHC service unit as the first level of contact, to triage preventive and curative care, chronic and acute care and co-ordinate the different levels of healthcare.[10] To strengthen the PHC services, the "Family Doctor Service Agreement (家庭醫生簽約服務)" policy has been promoted since 2016. Each resident is encouraged to contract a service agreement with a family doctor service team with members including family doctor, community nurse and public health practitioners for a package of PHC services, so that each resident can enjoy comprehensive, continuing and co-ordinated healthcare.[11] To enhance the capacity of PHC system in the districts, "Healthcare Networks (醫療聯合體)" are established according to the districts' characteristics under the government's leadership. The hospitals with more resources, particularly the larger public hospitals, take lead to network with the local PHC units and remote areas. With appropriate referral and collaboration mechanisms, the leading hospital provides management supports, clinical supports and training to member service units, aiming at optimising healthcare resources and enhancing the capacity of PHC, enabling patients with stable and chronic conditions to receive care in PHC or lower level care settings, and providing co-ordinated and continuing healthcare services from prevention, diagnosis, treatment, rehabilitation to long term care. Among the hospitals and PHC units, the roles and responsibilities, benefits distribution mechanism, referral system, and data sharing system for medical appointment, referral, health management and telemedicine are specified and established accordingly.[12]

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[5] 中華人民共和國國務院辦公廳 (2015)《國務院辦公廳關于印發全國醫療衛生服務體系規劃綱要(2015—2020年) 的通知》

[6] 新華社 (2016)《中共中央 國務院印發〈"健康中國2030" 規劃綱要〉》

[7] 新華社 (2018)《中共中央印發〈深化黨和國家機構改革方案〉》

[8] 中華人民共和國國家衛生健康委員會 (2019) 《健康中國行動 (2019—2030年) 》

[9] 新華社 (2019) 《中華人民共和國基本醫療衛生與健康促進法》

[10] 中華人民共和國中央人民政府 (2016)《建立 "基層首診、雙向轉診、急慢分治、上下聯動" 的分級診療模式》

[11] 中華人民共和國人力資源和社會保障部 (2016)《關於印發推進家庭醫生簽約服務指導意見的通知》

[12] 中華人民共和國國務院辦公廳 (2017)《國務院辦公廳關于推進醫療聯合體建設和發展的指導意見》; 中華人民共和國基層衛生健康司 (2019)《關于推進緊密型縣域醫療衛生共同體建設的通知》; 國家衛生健康委員會 (2020) 《醫療聯合體管理辦法 (試行) 》

B.10

Currently, PHC services play an essential role in the healthcare system of Mainland China. In 2021, 94.8 % of the healthcare service units were PHC service units, 50.2% of the total number of medical consultation was in PHC services. Healthcare financial protection has improved since the launch of the *National Healthcare System Planning Outlines 2015-2020*. As compared with 2015, individual's out-of-pocket expenditure as a percentage of the national health expenditure decreased from 29.97% to 27.7%; social health expenditure (including social health insurance, enterprise financing/insurance schemes and social institutions financing schemes) increased from 39.15% to 44.9%; and government expenditure decreased from 30.88% to 27.4% in 2021.[13] PHC teams are being strengthened with general practitioners as the focuses, PHC services improve gradually, and the equity and accessibility of basic healthcare services has been enhanced significantly.[14]

The United Kingdom

B.11

The National Health Service Act effective in 1948 stated that it should be the Government's duty to provide free healthcare services to secure the improvement of people's physical and mental health. The Act brought together a wide range of medical services under one organisation, National Health Service (NHS) has then been established. NHS is a huge organisation mainly funded by government from general taxation, with smaller proportion from National Insurance Contribution and private payment.[15]

B.12

NHS services are mostly free to ordinarily resident. Residents have to register a GP (i.e. family doctor) practice for NHS services. GP, the first point of contact of NHS services, works with a team of nurses, practice managers, healthcare assistants, receptionists and administrative staff in general practice. Pharmacists, occupational therapists, physiotherapists, midwives, district nurses, health visitors and other allied health professionals may be based in the same neighborhood of the GP. GP's referral is required for NHS specialist and hospital services, except for accessing emergency treatment, sexual health, substance misuse or alcohol services. Patients can book NHS hospital appointments online via the NHS e-Referral Service which covers every hospital and every GP practice. The data collected through e-Referral are used both for treatment cost recovery and service planning, with NHS Digital ensuring the safe and better use of data.[16]

B.13

In the community, GPs work together with community services, mental health services, social care, pharmacy, hospital and voluntary services to form a primary care network (PCN), with the lead of clinical director who may be a GP, general practice nurse, clinical pharmacist or other clinical profession working in general practice, enabling greater provision of proactive, personalised, co-ordinated and more integrated health and social care for people close to home. Each PCN usually serves a community of 30 000 to 50 000 people, a population size small enough to provide personal care, and large enough to have impact and economy of scale.[17] Practices are not mandated to join a PCN. However, over 99% GPs have signed up to a PCN. If they do not, they will lose out significant extra funding and their neighboring PCN will be funded to provide services to the patients whose practices are not covered by a PCN.[18]

B.14

For governance and quality assurance, the Department of Health and Social Care supports the Secretary of State for Health and Social Care and ministers to oversee health and social care policies and NHS service delivery to help people live more independent, healthier lives for longer. The Care Quality Commission (CQC) regulates health and social care services in England including NHS services through monitoring and inspection. CQC awards services a quality rating (four ratings, from Outstanding to Inadequate), which is required to be

[13] 國家衛生健康委員會(2022)《2021年我國衛生健康事業發展統計公報》；中國政府網(2016)《2015年我國衛生和計劃生育事業發展統計公報》

[14] 中華人民共和國國務院辦公廳 (2017) 《國務院辦公廳關于推進醫療聯合體建設和發展的指導意見》

[15] In 2018, 78% of health expenditure was financed by government scheme, 17% was out-of-pocket payments, 3% was by national health insurance and 3 % by other schemes. Source: OECD (2020). Health at a Glance: Europe 2020. Source: OECD (2020). Health at a Glance: Europe 2020.

[16] Royal College of General Practitioners (2011). It's Your Practice: A patient guide to GP services.

[17] NHS, the UK (2021). Primary care networks. [25] The King's Fund (2020). Primary care networks explained.

[18] The King's Fund (2020). Primary care networks explained.

displayed at service site. Poor performance is liable to fine penalty and cancellation of registration. CQC publishes their inspection reports and views for service improvements on their website.

B.15

Currently, under ageing population, and increasing service demand and health spending, NHS is running huge deficit[19]. The patients are experiencing longer waiting time for healthcare and lowering service quality. In 2014, the Government published a plan to improve primary care with personalised and proactive care for people most in need.[20] In 2019, NHS set out a *Long Term Plan* for healthcare improvement for the next five and ten years. The strategies include to give people more control over their own health and the care they receive, encourage more collaboration in PCNs, increase contribution to some of the most significant causes of ill health, increase the NHS workforce and enhance training, provide more convenient access to services and health information for patients, provide better access to digital tools and patient records for staff, improve on the analysis of patient and population data, reduce duplication in service delivery, and better use NHS' combined purchasing power to reduce the costs.[21] Embed the lesson learned from COVID-19 pandemic, Health and Care Act 2022 was enacted in April 2022 to support the effective delivery of the NHS *Long Term Plan* whilst strengthening democratic accountability through measures including the establishment of statutory Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) in every part of England to improve health and care systems integration and reduce bureaucracy in commissioning.[22]

B.16

With financial resources allocated from NHS England, ICBs are responsible for PHC commissioning (a process of service need assessment, planning, purchasing and monitoring), accountable for NHS spend and performance within the system, and have the flexibility to determine the governance structure (e.g. create committees) in their areas. ICP brings together ICBs, NHS providers with local authorities and other local partners to develop strategy for integrated care in the area.[23]

Singapore

B.17

The Government on one hand encourages the people to take responsibility for their own health, on the other hand prepares an "S+3M" (i.e. subsidy plus MediShield, MediSave and MediFund) multi-layered healthcare safety net to ensure affordable healthcare for all the people. Under low tax rates, public health expenditure is funded jointly by tax revenue, mandatory health insurance (i.e. MediShield Life, a basic health insurance plan contributed from employers and employees to pay for large hospital bills and selected costly out-patient treatments) and mandatory medical saving schemes (i.e. MediSave, a national savings scheme contributed from a proportion of people's income for future medical expenses) administered by Central Provident Fund. For patients who face financial difficulties on medical payment after receiving government subsidies and drawing on MediShield Life and MediSave, they can apply for the government endowment fund MediFund.[24]

B.18

PHC is the foundation of the healthcare system, patients' first point of contact in the community. PHC service providers treat acute conditions such as upper respiratory tract infections, manage chronic diseases, provide preventive care such as health screening, co-ordinate patients' care with other providers and support patients to seek appropriate specialised care. PHC services are provided through a network of 23 out-patient polyclinics and private 1 800 GP clinics. Polyclinics provide subsidised primary medical treatment, preventive care and health education.

[19] National Audit Office, the UK (2019). NHS financial sustainability.
[20] Department of Health, the UK (2014). Transforming Primary Care: Safe, proactive, personalised care for those who need it most.
[21] NHS, the UK (2019). NHS Long Term Plan.
[22] The National Archives (2022). Health and Care Act 2022.
[23] The National Archives (2022). Health and Care Act 2022.
[24] Ministry of Health, Singapore (2019). MediShield Life; MediSave; Medifund.

Private GP clinics serve about 80% of the overall primary care attendances, more than half of the patients travel less than 1 kilometer to seek medical care. To support GPs and patients on chronic disease management, the Government has developed five Community Health Centres (CHCs), eight Family Medicine Clinics (FMCs) and ten Primary Care Networks (PCNs). CHCs provide ancillary health services such as DM foot screening, nurse counseling and PT services to support GPs and chronic disease patients. FMCs are multi-doctor practice supported by a team of nurses and allied health professionals. PCNs is a network to support GPs with a team of nurses and care co-ordinators. PCN GPs register patients in a Chronic Disease Registry so that patient's progress and clinical outcomes are tracked and monitored. Patients would be referred to nurse counsellor and the relevant ancillary services such as Diabetic Foot Screening or Diabetic Retinal Photography if necessary. The electronic health record sharing system HealthHub acts as 'digital front-door' of government's PHC intiatives, facilitates co-ordination among the care providers and enables patient's access to their family doctor's care plan, their own medical record and management of their transaction and medical appointment via mobile phone or computer. In view of the ageing population, the Government established Agency for Integrated Care (AIC) in 2009 to co-ordinate elderly care services, and enhance service development and capability building across health and social domains. AIC reach out to elderly and their carers, strengthen partners' capability to deliver quality care, and bring partners together to meet elderly's needs.[25]

B.19

As the regional health manager for integrated care, the three healthcare clusters (namely, SingHealth, National University Health System and National Healthcare Group) work with Ministry of Health, operate a range of public hospitals and polyclinics, partner PCN to support private family doctors, bring together healthcare providers and community care partners to look after their region of each with about 1.5 million residents. SingHealth, for instance, is composed of acute hospitals, national specialty centres, community hospitals and polyclinics, collaborating with health and social care sectors in a regional health system. To strengthen community care, registered nurses from hospitals are deployed to Senior Activity Centres to deliver healthcare services in collaboration with medical social workers. Medical social workers work in public hospitals, national specialty centres, polyclinics, community hospitals, nursing homes and hospices in collaboration with healthcare professionals and community partners to provide psychosocial, environmental and financial support to patients and their families, and assist patients to transit to the community smoothly after hospital discharge. Patients support groups are also set up to support patients and caregivers. SingHealth charges on a fee for service basis. The fees on citizens and permanent residents are partly subsidised by government and partly paid by medical savings in Medisave. About half of the operation expenses is covered by government subvention.[26]

B.20

The Government and healthcare services encourage patients to visit GP first before going to A&E. A&E attendance fees is round $121 to $160 in Singapore dollar, a rate much higher than in Hong Kong. For non-acute conditions, it would be cheaper and faster to visit a GP or clinic which opens 24-hour or on extended hours daily.[27] In 2014, Changi General Hospital piloted a GPFirst Programme to encourage patients with non-emergency conditions to seek treatment at GP rather than A&E. If patients see GPs first and then be referred to A&E, they will be given priority to be seen earlier at A&E, and be given a $50 subsidy in Singapore dollar on their A&E bill to help offset the cost of the GP visit. In view of a reduction of self-referred attendances at A&E, the Government has expanded GPFirst Programme to involve more GPs in more regions.[28]

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[25] Ministry of Health, Singapore (2019). Primary Healthcare Services. Agency for Integrated Care, Singapore (2019). Primary Care Pages. Ministry of Health, Singapore (2019). HealthHub.

[26] SingHealth Group (2021). About us. Singapore Health Services (2020). SingHealth Duke-NUS Academic Medical Centre Annual Report 2019/2020.

[27] Consultation cost in 24-hour clinics is about $80 to $110 in Singapore dollar. There are about 28 clinics open 24 hours or on extended hours (usually up to 12:00 at midnight). In A&E, non-life-threatening cases will be triaged to lower priority and wait for longer hours. Source: Hospitals.SG. (2015). 24-hour Clinics. SingSaver PTE Ltd. (2021). A Complete Guide To 24-Hour Clinics In Singapore.

[28] Ministry of Health, Singapore (2020). The experience of the GPFirst Programme.

B.21

During COVID-19 pandemic, GPs has served as the first port of call for people in need of healthcare in the community. They deliver vaccination, out-patient consultations, health assessment, and manage home isolation patients together with polyclinics. The pandemic has strengthened the partnership between GPs and public healthcare programme. Leveraging on this foundation, the Government has launched "Healthier SG" strategy to focus on preventive care to address the challenges of ageing population and increasing chronic disease prevalence. With the White Paper on "Healthier SG" passed in October 2022, the national Healthier SG Enrolment Programme will be launched in the second half of 2023. The Programme will be open to residents aged 60 and above first, followed by those aged 40 to 59 in the next two years. Under the Programme, each enrollee will choose to enroll a family doctor/GP clinic, who will develop a care plan with the patient. Enrollee will receive regular scheduled check-ins at least once a year for health assessment, fully subsidised recommended screening and vaccination, partially subsidised chronic disease management, tracking of health results, and lifestyle adjustment advice if necessary. They may record the community activities and physical activities they participated for healthy lifestyle to earn Health Points through Healthy 365 App. The family doctor under the Programme will receive annual service fee on capitation basis and the overall performance of the Programme will be monitored with key performance indicators. To support this, training on community care and family medicine for medical students, doctors, nurses, pharmacists and allied health professionals will be enhanced, data system support and a one-off grant for family doctor's necessary IT setup will be provided, and new legislation to mandate data governance and contribution of electronic health record to the National Electronic Health Record system will be developed.[29]

Australia

B.22

In Australia, Health Council is the overarching oversight body to shape Australia's health system and regulate service delivery of all health professionals. Australia is under the challenges of ageing population and higher chronic diseases prevalence. The proportion of population aged 65 years and above was 16.1% in 2020 and more rapid increase is projected for the next decade.[30] 47% of the population were estimated to have one or more of the 10 selected chronic conditions in 2020-21.[31] In view of this, Australia takes a national approach to co-ordinate care through Primary Health Networks (PHNs) and GP-led team in local areas. The Government developed the National Primary Health Care Strategic Framework in 2013 to strengthen the PHC system. Following a review on the traditional government funded services by Medicare Locals, which have confused roles of primary care providers, service co-ordinator and purchaser,[32] the Government established 31 PHNs in 2015. The role of PHNs is to commission and co-ordinate services, rather than provide services. PHNs receive funding from the Government to commission services, which is a strategic and evidence-based approach of service planning and purchasing. They establish GP-led Clinical Councils and Community Advisory Committees to include clinicians and the community in their decisions about PHC services. They develop partnerships that bring together different health providers and state and territory-based health authorities to connect different elements of health system for integrated health services. They also work closely with GPs and other PHC providers in local areas to build their capacity, monitor their performance and implement change. Digital health and information sharing systems for providers and patients are developed to support the service integration. PHNs' seven priority work areas include mental health, Aboriginal and Torres Strait Islander health, population health, digital health, health workforce, aged care, and alcohol and other drugs.[33]

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[29] Ministry of Health, Singapore (2022). Healthier SG.
[30] Australian Bureau of Statistics (2019). Twenty years of population change.
[31] Australian Institute of Health and Welfare, Australian Government (2022). Chronic conditions and multimorbidity.
[32] John Horvath AO (2014). Review of Medicare Locals: Report to the Minister for Health and Minister for Sport.
[33] Department of Health, Australian Government (2018). PHN Background; Fact Sheet: Primary Health Networks.

B.23
PHC in the community is the first point of contact of healthcare services in most cases. Services provided include health promotion, prevention and screening, early intervention, treatment and management. GPs play the central role in PHC, working together with nurses, allied health professionals, midwives, pharmacists, dentists, and Aboriginal health workers.[34] GP is the gate-keeper of public secondary and tertiary care, GP referral is necessary for specialist services covered by Medicare, Australia's universal health insurance scheme.[35] If patients need after-hours GP services, they could call a free government-funded GP helpline. Registered nurse will provide healthcare information and advice. If necessary, a GP will call back in an hour. If call-out services is needed, private after-hours doctor could reach out the community in major cities and centres.

B.24
Australia has a high public expenditure on health[36] financed by high tax rates[37]. Under the coverage of universal health insurance scheme Medicare, residents have access to a wide range of services at low or no cost, including medical services provided by doctors, specialists and other health professionals, hospital treatment and prescription medicines.[38] Medicare is financed from taxation revenue and levy. Most taxpayers pay a Medicare Levy of 2% of their taxable income. The Government imposes an extra 1% to 1.5% Medicare Levy Surcharge to the higher income groups if they do not have Private Hospital Cover for additional coverage in private healthcare services.[39]

B.25
Australia has a comprehensive list of indicators in the Health Performance Framework to monitor and evaluate the performance of healthcare of different State or Territory across years. The Australia Government analyses the data and reports it publicly on Australia's Health, providing reference for healthcare decision making.[40]

New Zealand

B.26
The Ministry of Health is the Government's chief strategic advisor and steward of the health and disability system. It appoints statutory advisory committees, regulatory authorities and Crown entities to provide advice on healthcare policies and funding allocation, and regulate the qualities of healthcare and healthcare professionals. The Ministry of Health collects data through established administrative systems and national population health surveys to monitor the health of New Zealanders, manage subsidies and services, and inform policy decisions, etc., and report the performance of the system and providers with health indicators publicly each year.

B.27
With the Pae Ora (Healthy Futures) Act effective on 1 July 2022 after the Health and Disability System Review, four new entities, namely, Public Health Agency, Health New Zealand (Health NZ), Māori Health Authority and Ministry of Disabled People, are established to transform the health and disability system to support all New Zealanders to live longer and have the best possible quality of life. Public Health Agency is established within the Ministry of Health to provide system leadership for public health and advise the Director-General and the Minister of Health and Associates on public health matters. Health NZ weaves the functions of the 20 former District Health Boards (DHBs) into its regional divisions and district offices, and takes over the commissioning and operational roles, while the role of Ministry of Health focuses on stewardship, strategy and policy. Health NZ is responsible for day-to-day running of the whole health system, including primary and community care, and hospital and specialist services at local, district, regional and national levels. Māori Health Authority is established to support the Ministry of Health in shaping policy and strategy, and commission services for Māori communities in partnership with Health NZ.[41]

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[34] Standing Council on Health, Commonwealth of Australia (2013). National Primary Health Care Strategic Framework.
[35] healthdirect, Australia (2018). Australia's healthcare system.
[36] Government health expenditure to tax is 24.4% in 2017-18. Source: Australian Institute of Health and Welfare, Australian Government (2019). Health expenditure Australia 2017–18.
[37] The highest marginal individual tax rate is about 45%.
[38] healthdirect, Australia (2020). What is Medicare?
[39] Australian Taxation Office (2022). Medicare levy.
[40] Australian Institute of Health and Welfare, Australian Government (2021). Australia's health performance framework. Australian Institute of Health and Welfare, Australian Government (2022). Australia's Health 2022.
[41] Health New Zealand, New Zealand Government (2022). About Us. Ministry of Health, New Zealand (2021). Strategic Intentions 2021 to 2025.

For disabled people, the Ministry of Disabled People is established to provide a wider lens on disability across the Government, and to drive transformation of disability support system and enable disabled people and their families to create good lives for themselves.[42]

B.28

About 80% of New Zealand's total health expenditure is funded by government from general taxation, with smaller proportion from out-of-pocket and private health insurance. More than three-quarters the public funds is allocated to the districts, about 19% is for national health services and about 1% is for running the Ministry of Health.[43] Disability support services and some health services are funded and purchased nationally by the Ministry of Health for the districts through Health NZ. Health NZ funds Primary Health Organisations (PHOs) to provide subsidised PHC services through general practices to people who have enrolled with a PHO. Most general practices are part of a PHO, which brings together GPs, nurses and other healthcare professionals in the community to ensure a seamless continuum of care between general practice services and other healthcare services, in particular to better manage chronic conditions.[44]

B.29

To address the challenges of ageing population with PHC reform, the experience of Canterbury is worthy of reference. Canterbury DHB is the largest by population of aged 75 and above and the second largest by population (over half a million people) among the 20 DHBs in New Zealand. In 2007, the DHB realised that the healthcare system would be unsustainable if nothing changed. With challenges included culminating deficit, amid rising admissions, growing waiting time and rapidly ageing population, they would need more hospital, doctors, nurses and care beds for the elderly, which would be unaffordable for Canterbury. Through public consultation, it was agreed that there had to be 'one system, one budget' for both health and social care. The patient should be at the centre of the health and social care service system. With the support of HealthPathways, PHC teams (with GPs, nurses, pharmacists and other healthcare professionals) were empowered with the skills and treatment information from hospital specialist doctors so that they could provide more specialised services which were normally provided in hospitals.[45] Electronic Shared Care Record View (a data portal which was built on the existing systems of individual GPs, hospitals and other services' databases) provided a comprehensive care record accessible across GPs. Electronic Request Management System (a referral system among private and public healthcare services) enabled GPs, community nurses, pharmacists, specialists and hospitals to collaborate better in community care. With the PHC reforms, Canterbury has coped with the growing healthcare demand from ageing population without expanding hospital capacity, reduced acute and emergency admissions, shortened the length of hospital stay, and turned financial deficit to surplus.[46]

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[42] Ministry of Disabled People, New Zealand Government (2022). About Us.

[43] Ministry of Health, New Zealand (2016). Funding.

[44] Ministry of Health, New Zealand (2022). New Zealand health system. Ministry of Health, New Zealand (2022). About primary health organisations.

[45] e.g. skin lesions removals for skin cancer at-risk cases, treatment for heavy menstrual bleeding and insertion of intrauterine device.

[46] Since 2008, the emergency department inpatient admissions of patients aged 60 and above from GP referral, admissions in aged residential care, and bed days for rest home care have been decreasing. The acute medical admissions and length of medical case stay are also lower than other DHBs. Source: Gullery, C., & Hamilton, G. (2015). Towards integrated person-centred healthcare–the Canterbury journey. Timmins, N., & Ham, C. (2013). The quest for integrated health and social care: a case study in Canterbury, New Zealand.

APPENDIX C –
THE DEVELOPMENT OF PRIMARY HEALTHCARE IN HONG KONG

C.1
PHC is the first point of contact for individuals and families in a continuous healthcare process in the living and working community which entails the provision of accessible, comprehensive, continuing, co-ordinated and person-centred care. A well-established and overarching PHC system routinely manages, maintains and enhance the health of the population at the community level, forms the foundation and portal of the pyramid of healthcare services, and serves as a gatekeeping role to specialised secondary and tertiary healthcare in hospital and institution settings. It is recognised as the most essential component in a well-functioning healthcare system.

C.2
PHC development in Hong Kong could be traced back to the document *Health for all, the way ahead: Report of the Working Party on Primary Health Care* in 1990. The Working Party reviewed the Government's role and objectives in health and PHC. It was aware that the Government sector shared 15% of all out-patient medical consultations. With rising public expectations for quality healthcare and need to promote PHC, the "public assistant for all" approach was no longer appropriate. The Government should not aim to become the sole or main provider in primary medical care. The Government's role should be emphasised on public health and preventive care through multi-sector co-ordinated collaboration, and ensuring and improving the quality and standard of primary care, as well as providing primary care for those who cannot afford private healthcare. The Report affirms the importance of PHC and provided a list of 102 recommendations toward its development.

C.3
In the following 10 years, the establishment of the HA in 1990 and the public consultations in 1993 and 1999[47] had brought the public's attention to the restructuring of public healthcare services and healthcare financing, which eventually revealed the importance of PHC reform again in 2000, with the release of the consultation document *Lifelong Investment in Health*. The recommendations include strengthening preventive care, developing Chinese medicine services, transferring the DH's GOPCs into the HA for integration of primary and secondary care in public sector, and developing electronic Health Information Infrastructure.

C.4
In 2005, the Health and Medical Development Advisory Committee reviewed the service delivery model for the healthcare system, and issued a discussion paper *Building a Healthy Tomorrow*. The recommendations include promoting the concept of family doctor, the target services of public healthcare, purchasing primary care services from the private sector, and facilitating the collaboration among healthcare professionals for co-ordinated care.

C.5
CBuilding on the recommendations, the Government put forward a comprehensive proposal in *Your health Your life Consultation Document on Healthcare Reform* and published the Report on First Stage Consultation in 2008. The recommendations include establishing a family doctor register, developing basic models for primary care services, promoting PPP, subsidising target groups for preventive care, and purchasing primary care services from private sector. The principles of good primary care received

[47] The Government invited public comments on the consultation document Towards Better Health - A Consultation Document about compulsory comprehensive insurance in 1993. The debate continued with the release of Harvard Report to recommend health security plan and saving accounts for long-term care and the consultation document Improving Hong Kong's HealthCare System: Why and For Whom in 1999.

positive feedback from the public and healthcare stakeholders. Some respondents expressed support to the establishment of a PHC authority for the planning, co-ordination and governance of PHC services. The Government reconvened the Working Group on Primary Care (WGPC) and three Task Forces under the WGPC to advise on strategic directions for primary care development in 2008.

C.6
Based on the strategies and recommendations proposed by WGPC and its Task Forces, the Government published the *Our partner for better health – Primary Care Development in Hong Kong: Strategy Document* in 2010. The recommendations include setting up a Primary Care Office (PCO), developing Reference Frameworks and Primary Care Directory, and piloting Community Health Centres and networks to devise service models with comprehensive and co-ordinated PHC services through cross-sectoral collaboration in the community.

C.7
Following the announcement in the 2017 Policy Address, the Steering Committee on Primary Healthcare Development was set up in November 2017 to develop the blueprint for the sustainable development of PHC services for Hong Kong.

C.8
In the 2017 and 2018 Policy Addresses, it was announced that the Government is committed to enhancing district-based PHC services in order to effectively change the current focus of healthcare services on treatment to alleviate the pressure on public hospitals by setting up DHCs in 18 districts progressively. Against this backdrop, the PHO was established on 1 March 2019 directly under the HHB to oversee and steer the development of PHC services at the bureau level. PHO focuses on the development of DHCs as a new service model and spearheads the overall review and future development of PHC services. With the setting up of PHO, PCO was formally integrated into PHO in October 2019 to allow better use of healthcare resources and to streamline the roles and responsibilities of the two offices.

C.9
The development of PHC in Hong Kong is briefly illustrated in Figure C.1. The recommendations in the policy and consultation documents for PHC development since the Report in 1990 is set out in Figure C.2.

Figure C.1:
PHC Development in Hong Kong

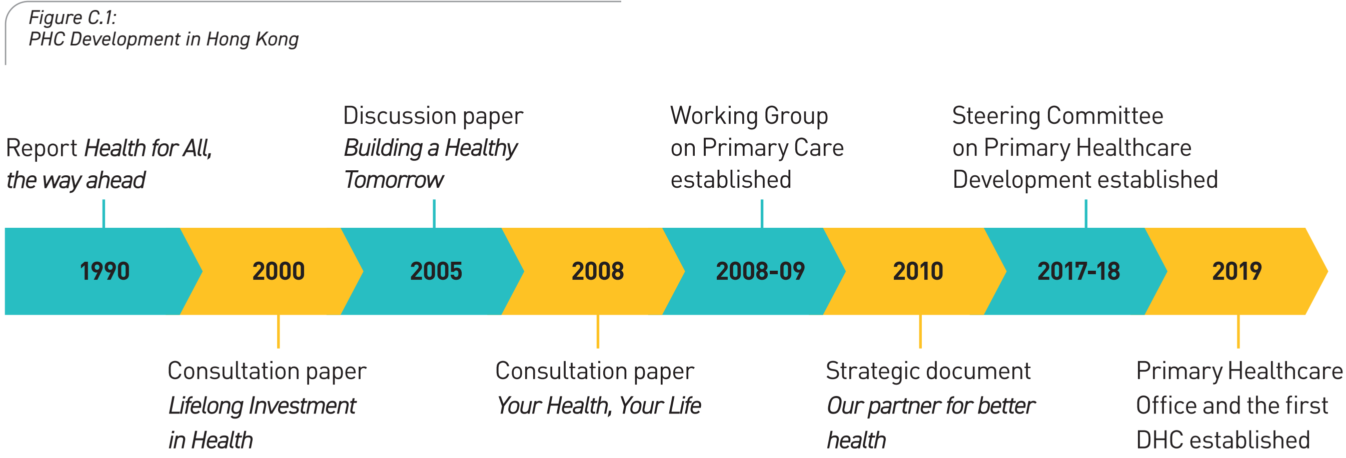

Table C.2:
The recommendations in the policy and consultation documents for the development of PHC

	RECOMMENDATIONS					
Policy areas	*Health for all, the way ahead: Report of the Working Party on Primary Health Care (1990)*	*Lifelong Investment in Health consultation document (2000)*	*Building a Healthy Tomorrow discussion paper (2005)*	*Your Health, Your Life - Healthcare Reform Consultation Document and Report on First Stage Consultation (2008)*	*Our partner for better health – Primary Care Development in Hong Kong: Strategy Document (2010)*	**Policy Addresses in 2017 and 2018**
Governance and quality assurance	• Establish a statutory Primary Healthcare Authority with some degree of financial autonomy, with the DH as its executive arm, to oversee the delivery of PHC.	• The DH to take up the role as the coordinator or regulator to ensure quality in the health care sector. • Set up a Complaint Office in the DH to assist the patients in lodging complaints.		• Set up Working Group on Primary Care. • Establish a PHC authority to co-ordinate all primary care initiatives. • Establish a family doctor register.	• Set up a Primary Care Office for support and co-ordination of efforts for primary care across sectors. • Develop Reference Frameworks and Primary Care Directory.	• Set up Steering Committee on Primary Healthcare. • Pursue the Accredited Registers Scheme for Healthcare Professions. • Set up an Office for Regulation of Private Healthcare Facilities; introduce legislation to regulate Advanced Therapy Products. • Complete and evaluate the Pilot Accredited Registers Scheme for Healthcare Professions.
Development of preventive and promotive PHC services	• Strengthen the planning, policy, leadership, training and service on health education and promotion. • Improve preventive care, including immunization, maternal and child care, family health, family planning, student health and other disease prevention and control services. • PHC services in public and private sectors should be promotive and preventive, with better planning and co-ordination. • Screening and health education programmes should target towards diseases or at-risk groups, and be evaluated.	•Strengthen preventive care: work with all related sectors, including healthcare, education, environment and others. • The DH to review the effectiveness of health education and promotion efforts. • GOPCs should be redesigned for the financially vulnerable and those chronically ill. • The DH to promote oral health to the community and students. • The DH to support the development of Chinese medicine in Hong Kong. • Pilot the practice of Chinese medicine in public hospitals.	• Public healthcare should target the services for (1) acute and emergency care; (2) low income and under-privileged groups; (3) illnesses that entail high cost, advanced technology and multi-disciplinary professional team work; and (4) training of healthcare professionals.	• Strengthen public health education, healthy lifestyle promotion, disease prevention, as well as development of and standard-setting for primary care services.	• Strengthen preventive approach to tackle major disease burden, particularly chronic diseases. • Emphasise person-centred care and patient empowerment. • Additional resources for pilot dental services for the elderly.	• Set up a dedicated unit under HHB to oversee Chinese medicine development. establish a dedicated fund to promote Chinese medicine development. • Introduce free HPV vaccination to school girls of particular age groups.

Service co-ordination and collaboration	• Enhance the system for better collaboration between general and specialist out-patient services. • More integrated community health services for elderly.	• The DH's GOPCs be transferred to the HA for integration of the primary and secondary care in the public sector. • Develop a multi-disciplinary, multi-sectoral, community-based integrated healthcare model with medical social collaboration.	• Promote the family doctor concept and continuity of care. • Encourage group practice of private doctors and empowerment of patients. • The public sector co-ordinates the planning and development of ambulatory services with private hospitals. • Public hospitals establish referral protocols and shared-care programmes with family doctors for medically stable patients.	• Develop basic models for primary care services.	• Develop comprehensive care by multi-disciplinary teams. • Improve continuity of care for individuals. • Improve the co-ordination and collaboration of care among healthcare professionals across different sectors.	• Regularise Dementia Community Support Scheme and extend it to all district elderly community centres.
Development of district health system	• PHC services should be organised and administered in a district health system. Ngau Tau Kok Clinic and Yan Oi Polyclinic should be developed into DHCs for piloting service improvement.	• Develop a community-focused, patient-centred and knowledge-based integrated health care service.	• Establish a platform on a regional / district basis to facilitate collaboration among medical and other professionals.		• Pilot projects on Community Health Centres and networks.	• Set up District Health Centres, complemented by Satellite Centres, in 18 districts progressively.
Financing of PHC services	• *A charging policy should be adopted to identify the target groups for subsidised services and ensure no one be prevented from adequate medical treatment due to lack of means.* • *Different subsidisation levels for different services and target groups.[48] Fee adjustment should be gradual and step-by-step.* • *Study should be conducted leading to a policy statement on future health financing and service development.*	• Public funding should be allocated toward community-based services and based on population needs. • Introduce medical savings through a scheme of Health Protection Accounts. • Conduct a detailed study of the fees structure and how it can target subsidies at areas of greatest needs.	• Purchase primary medical care services from the private sector. • Develop more refined assessment to determine different subsidy level for patients with different needs.	• Promote PPP; funding injection for Samaritan Fund and PPP projects. • Subsidise target groups for preventive care. • Purchase primary care services from private sector. • Explore the idea of a "personal limit on medical expenses". • Public healthcare as a safety net for all, while providing better and wider choice in private healthcare. • In line with the concept of "money-follows-patient", while ensuring price transparency and cost-effectiveness.		

[48] (1) Preventive care, including immunization, maternal and child care, family planning, student health and other services for the control of diseases should be free of charge; (2) Primary care, including screening, for those who cannot afford to pay (e.g. recipients of public assistance) should be free of charge; (3) Screening for elderly and at-risk groups aged 45 to 64 in GOPC and Well-woman Clinics should be at reduced charges; (4) Primary care for young children aged 0 to 15, full-time students up to the age of 18, elderly aged 65 and above, and recipients of disability allowance, should be half fee; (5) Community rehabilitation services, community nursing service and domiciliary occupational therapy service should be of high subsidisation level; and (6) Non-target group should not be charged above the cost.

Manpower supply and training for PHC	• Enhance the role community nursing service through training and education; enhance public health nursing training and education. • More training to improve occupational health. • Enhance the training of doctors and nurses in GOPC and private practice, with clinic assistance to share less technical work. • Enhance training and education on family medicine. • Separate department of family medicine in the two universities. • The DH to set up PHC training centres.	• Promote family medicine practice by doctors, nurses and allied health professionals and provide the relevant training opportunities through the HA and GOPCs.	• Encourage additional training and qualifications for the career of community nurse through universities and training institutions.		• Support professional development and quality improvement.	• Increase the number of publicly-funded healthcare training places; upgrade and increase the teaching facilities.
Data connectivity and health surveillance	• Improve the collection, analysis and utilization of health information. • Develop a computer-based clinical information system for GOPC. • Expand the DH's Statistical Unit to become a Health Information Unit. • The DH to collaborate with other parties to carry out health services research. • Set up Health Services Research Fund. • Improve the communication of epidemiologic information between DH and private practitioners.	• The DH to report the health status of the community regularly, carry out health impact assessment of socio-economic variables and different environmental problems. • Develop an electronic Health Information Infrastructure to link up providers in the community. • The HA to develop knowledge-management tools such as evidence-based clinical practices. • Set up a Research Office in the Bureau.	• Provide health information by government to improve preventive care.	• Develop the infrastructure for sharing electronic health records in both the public and private sectors.	• Develop a territory-wide patient oriented Electronic Health Record Sharing System (eHealth). • Strengthen research on primary care.	• Establish a steering committee to lead the study on strategies for developing genomic medicine in Hong Kong.

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