HEALTH FOR ALL

THE WAY AHEAD

Report of the Working Party on Primary Health Care

December 1990
Hong Kong

基層健康服務工作小組

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本署檔號 OUR REF.:

來函檔號 YOUR REF.:

28 December 1990

His Excellency Sir David Wilson, KCMG
Governor of Hong Kong

Your Excellency,

Report of the
Working Party on Primary Health Care

We were appointed to the Working Party on Primary Health Care in August 1989 to review and make recommendations on the delivery of primary health care in Hong Kong.

We now have the honour to submit our Report. The current world trend in the delivery of medical services places increasing emphasis on primary health care. We believe that the early implementation of our recommendations will enable Hong Kong to keep pace with this trend and lay a firm foundation for the future health care system.

In view of the public interest in this review and the importance of community participation in health care, we recommend that this Report be published in due course.

We have the honour to be
Your Excellency's obedient servants,

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ACC. NO. Not Acc. 12/71
CLASS W/04.6/HEA
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Abbreviations Used in the Report

AIDS	Acquired Immune Deficiency Syndrome
C&A Homes	Care & Attention Homes
CHEU	Central Health Education Unit
CNS	Community Nursing Service
COS	Comprehensive Observation Service
CSP	Combined Screening Programme
CUHK	The Chinese University of Hong Kong
DOT	Domiciliary Occupational Therapy
EDA	Estate Doctors Association
FHS	Family Health Service
GOP	General Out-Patient
HKCGP	Hong Kong College of General Practitioners
HKCSS	Hong Kong Council of Social Service
HKU	University of Hong Kong
HSD	Hospital Services Department
MDAC	Medical Development Advisory Committee
MCH	Maternal and Child Health
PHA	Provisional Hospital Authority
PHC	Primary Health Care
RACGP	Royal Australian College of General Practitioners
SHS	Student Health Service
SM&HO	Senior Medical and Health Officer
SMS	School Medical Service
SWD	Social Welfare Department
WHO	World Health Organization

CHAPTER ONE

OVERVIEW

Health of the Community

1.1. The general level of health of the Hong Kong population is good. This is reflected in our highly satisfactory health indices. Infant mortality rate per 1 000 live births has dropped from 26.4 in 1964 to 6.9 in 1989, one of the lowest among developed countries. Maternal mortality rate per 1 000 total births has decreased from 0.38 to 0.06 during the same period. The average life expectancy at birth is 80 for females and 74 for males[1]. Notifications of the major

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[1] A comparison of health indices of Hong Kong with four selected economies in 1988 is as follows -

	Infant Mortality (Deaths per 1 000 live births)	Life Expectancy at Birth	
		Male	Female
Hong Kong	**7.4**	**74.4**	**79.9**
Japan*	4.6	75.5	81.3
Singapore	7.0	71.7	76.3
UK	9.0	72.5	78.1
USA**	10.1	71.5	78.4

* Provisional/preliminary figure

** These are figures for 1987 which are the latest available.

Source : A Comparison of the Economic and Social Situation of Hong Kong with Ten Selected Economies 1990, published by the Census & Statistics Department.

communicable diseases have reduced over the years and are at a low level.

1.2. These proud achievements are the results of socio-economic progress, improvement in nutrition, hygiene and sanitation and development of medical and health services. The latter includes a highly effective immunization and communicable disease control programme, provision of universally accessible medical care and advancement in medical science and technology.

Historical Development of Medical and Health Services

1.3. In the immediate post-war years, faced with an influx of returning residents and refugees, the priority of the Government medical services was control and prevention of communicable diseases. This was necessitated by poor nutrition, congested living conditions and inadequate supply of safe water and sanitation at that time. Progress in developing Government facilities for in-patients and out-patients was slow. The voluntary and charitable organizations played a crucial part in providing the much needed medical care through hospitals and clinics.

1.4. The first Government medical development plan was drawn up in the early 1960s in accordance with -

(a) the declared policy to provide heavily subsidized or free medical and personal health services to that large section of the community which was unable to seek medical care from other sources; and

(b) the minimum ratios of providing hospital and clinic facilities to meet these needs[2].

For instance, the then established standards required the provision of 4.25 hospital beds per 1 000 population and one standard urban clinic per 100 000 urban population by 1972. Accordingly, additional hospitals and clinics were built to meet those standards.

1.5. This medical development plan was updated in 1974 with the publication of the White Paper on The Further Development of Medical and Health Services in Hong Kong. In terms of health care policy, the main thrust continued to be providing medical services at a nominal charge for all those who had to rely on heavily subsidized medical care. This White Paper was concerned "primarily with the action needed to expand the major areas of the Government's medical and health services, that is to say, with the maintenance and expansion of the general public health services (including the prevention and control of disease) and with the development of additional facilities and services for in-patients and out-patients"[3].

1.6. The 15 years following the publication of the 1974 White Paper saw a rapid expansion in medical and health facilities. The number of hospital beds has

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[2] These were contained in the White Paper on The Development of Medical Services in Hong Kong published in 1964.

[3] From White Paper on The Further Development of Medical and Health Services in Hong Kong, July 1974, paragraph 1.1.

increased steadily from 17 034 in 1974 to 25 059 in 1989, with the bed : population ratio rising from 3.89 to 4.35 per 1 000 people during the same period. By comparison, the general out-patient service providing primary medical care to the public has grown at a slower pace, from 44 to 54 clinics and many have developed to ensure basic provision to new towns.

1.7. From this synopsis, we can see how our health care system has shifted from pre-occupation with public health for the community as a whole to emphasis on provision of extensive facilities for treatment of the sick. Despite impressive achievements in public health, development of primary health care services has lagged behind hospital services. Overall, medical care has become highly hospital-oriented. One notable exception is the maternal and child health service, which provides an effective and high-quality service for women of child-bearing age and children from birth to five years through a network of community-based MCH centres.

1.8. Primary health care with its strong emphasis on health promotion, disease prevention, continuity of care, health maintenance and rehabilitation of chronic patients and the disabled in the community, with due involvement of the community and individuals, has not been fully developed. For instance, despite changes in disease pattern and the profile of users, the GOP clinics originally set up for surveillance over communicable diseases and screening for referral to specialist care have remained much the same as they were decades ago. Patients attending GOP clinics are provided mainly with curative care for minor ailments on an episodic basis. Comprehensive care is lacking and continuity of care is poorly maintained.

1.9. The concept of primary health care as the base of a health care system on which rest the more expensive and more specialized medical services has not received adequate attention. Its role as the "gatekeeper" of the hospital, by managing patients whose medical conditions do not necessarily require hospital investigation or treatment, has not been fully appreciated. As a result, a very large amount of medical care has taken place in the hospitals including their accident and emergency services which are often used for less critical complaints. The public hospital service, which is virtually free for all, has thus become progressively overburdened.

Changes in Public Hospital Services

1.10. The 1974 White Paper mapped out an ambitious programme for the building of more hospitals and clinics. However, it was recognized in the early 1980s that expansion of services alone cannot solve all the problems, notably overcrowding in public hospitals and long queues at both specialist and general out-patient clinics. In addition, the problems are likely to be compounded in the coming years by the rising community expectations for better medical and health services and the escalating costs of medical care, particularly those highly-specialized treatment procedures in hospitals.

1.11. In February 1985, a firm of Australian management consultants : W D Scott Pty Co. was commissioned to carry out a review of medical services. Regrettably, this review was confined to the management and administration of government and subvented hospitals instead of examining the health care system as a whole on the grounds that delivery of hospital services was

facing pressing problems and warranted particular attention at that time. In fact, the consultants themselves acknowledged that "the review would have to take account of the important relationships between the hospitals and the medical services outside their walls" and that "any change in the overall organizational arrangements for medical services will, of necessity, have some impact on the structures for public health"[4]. Restricted by their terms of reference, no detailed analysis was made of these important aspects. The consultants submitted their report to the Government in December 1985.

1.12. Following public consultation on the consultants' report, Government decided in 1987 that a statutory Hospital Authority outside the Civil Service should be set up to oversee the delivery of services in all government and subvented hospitals. Responsibility for public health and preventive programmes should however rest with a Department of Health, which should continue to be a Government department. To pave the way for the Authority, the then Medical and Health Department was split into the Department of Health and the Hospital Services Department on 1 April 1989. The Hospital Authority Ordinance was enacted on 26 July 1990 and the Authority came into existence on 1 December 1990.

Need for Primary Health Care Review

1.13. Developments in the public hospital system

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[4] From Report on The Delivery of Medical Services in Hospitals by W D Scott Pty Co, December 1985, page 1-2.

have brought into sharper focus the importance of primary health care and the need for improving the service. Critics point out, quite rightly, that even with better managed hospitals, the cost of unnecessary admissions to hospitals is high. A hospital-based approach to the delivery of health services is also not in the best interest of the community. The imbalance in our health care system, in resource allocation and in general emphasis, needs to be redressed : comprehensive primary health care should be developed and proper interface with hospital and specialist services should be achieved. A firm commitment to primary health care is also in line with the WHO recommended strategy for achieving the goal of Health For All.

1.14. During the debate on the Governor's policy address to the Legislative Council in November 1988, the Secretary for Health and Welfare acknowledged that "public expectations of the services provided by out-patient clinics were rising and the demands on them changing". He agreed that "it was time to re-evaluate their role and, in particular, to consider the interface between primary health care services and the services of the future Hospital Authority". He announced that "the commencement of such a review would be a high priority in the next few months".

1.15. Proposals for the format and ambit of the primary health care review were subsequently considered in detail by the Medical Development Advisory Committee. The Working Party on Primary Health Care was appointed in August 1989 for this very important assignment.

Overall Summary and Recommendations

1.16. Hong Kong is not unique in having developed a hospital-based health care system. This has been the experience of many territories over the past few decades. It is always easier to refer to the availability of highly-specialized, life-saving treatment procedures as improvement in medical care than increased health awareness among the community. It is also more impressive to point to a new hospital or sophisticated medical equipment as evidence of achievement in health services than enhanced activities in disease prevention, health promotion or education.

1.17. Following the International Conference on Primary Health Care held at Alma-Ata in 1978, many countries have responded positively to the Conference Declaration that Primary Health Care is the key to achieving the target of 'Health for All by the Year 2000'. In the light of rising health costs and the need for greater effectiveness, developed countries such as Canada, Australia and those in Europe have taken the lead in re-orientating their health systems towards primary health care. This is reflected in both national health policies and a shift of resources and attention from hospital to primary health care services. Hong Kong has not kept pace with this world trend in the delivery of medical services.

1.18. Our **first and foremost** recommendation is therefore for Government to make a clear commitment to adjusting the emphasis towards primary health care in Hong Kong's health care policy.

1.19. Our deliberations on primary health care were hampered to a certain extent by the absence of a clearly defined and up-to-date overall health care policy, except the one which dates back to the 1974 White Paper on the Further Development of Medical and Health Services in Hong Kong. We have therefore established, at the outset, our proposed objectives and principles in the development of primary health care. We consider that within the wide scope of primary health care, a distinction should be drawn between **public health services** including promotion of general health of the community and prevention of diseases and **primary medical care** providing first-contact curative care for the individual patient[5]. Whilst provision of public health and preventive care services for the population as a whole should remain primarily Government's responsibility, its role in primary medical care should be to ensure the existence of a framework for the delivery of quality care without Government being the main service provider. However, such a framework should continue to ensure that **no one should be prevented, through lack of means, from obtaining adequate medical treatment.**

1.20. Our proposed objectives in respect of how primary medical care should be delivered could only be

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[5] Primary medical care has often been mistaken as a synonym for primary health care. Primary medical care is one component of primary health care and is that part of the curative service where the patient usually makes his first contact with the doctor and has direct access to him. Primary health care, on the other hand, embraces strong elements of health promotion, disease prevention, rehabilitation and maintenance of the health of chronic patients and the disabled.

achieved in the longer term. In the immediate future, we envisage the retention and further development of a public sector primary medical care system to provide quality care to patients and to serve as training centres for doctors in primary care.

1.21. There are strengths and weaknesses in the present delivery of promotive, preventive, curative and rehabilitative services. We consider that different approaches should be adopted in improving existing services having regard to the validity of their objectives, the organization and delivery of these services and their effectiveness in meeting the health needs of our community.

1.22. We recommend that the following services should be improved on the basis of the existing framework and with greater participation by the community, the health care professionals and individuals -

(a) health education;

(b) family health service;

(c) immunization; and

(d) control of communicable and non-communicable diseases.

1.23. We recommend that major new initiatives should be undertaken in respect of the following areas of health activities to take account of changing needs -

(a) occupational health;

(b) health screening;

(c) health information;

(d) health services research; and

(e) community health care including rehabilitative services.

1.24. On provision of health services to students, we consider that the considerations which led to the introduction of the School Medical Service in 1964 providing heavily subsidized medical treatment for all school children no longer apply today. To promote and maintain the health of school children and to make the most effective use of existing resources, we recommend that a new Student Health Service operated by the Department of Health should be introduced to replace the School Medical Service.

1.25. Similarly, the general out-patient service requires major revamping in terms of its objectives, scope of service, operation and management. We recommend the development of family medicine in GOP clinics. Training programmes to equip doctors and nurses to provide a family medical service, which will act as a benchmark for the delivery of primary medical care in Hong Kong, should be a priority and an integral part of the general out-patient service.

1.26. Since private practitioners are providing some 70% of all medical consultations, our review would be incomplete if we were to confine our proposals for

overall improvement in medical care to the public sector. Apart from encouraging doctors in private practice to adopt good medical practices through reforms in the public sector, we recommend that new schemes for collaboration between the public and private sectors should be introduced. One such arrangement is to contract out the operation of public clinics to doctors in the non-government sector under a set of specified conditions and subject to close monitoring by the Department of Health.

1.27. To ensure an adequate supply of well-trained personnel in primary health care, we consider it essential to develop proper training. Adequate opportunities and resources should be provided for undergraduate and postgraduate training of doctors in primary health care, particularly in the specialties of family medicine and community medicine. The two training centres and other ancillary educational facilities that the Director of Health has proposed to develop at the Ngau Tau Kok Clinic and the Yan Oi Polyclinic should be set up as soon as possible. Nurses and other health care professionals should also be adequately trained for their responsibilities in primary health care. The concept of teamwork should be stressed. Above all, there should be adequate incentives for them to stay on : career prospects for health care professionals in primary health care should be improved.

1.28. We have addressed issues of organization and management of primary health care services to ensure that improvement to services would take place in an integrated manner, in accordance with the following fundamental principles of primary health care -

(a) support of and interface with other levels of the health system;

(b) co-ordination with other sectors; and

(c) participation of the community.

1.29. At the central level, we recommend the formation of a statutory **Primary Health Care Authority** with the Department of Health as its executive arm to oversee the delivery of primary health care. At the district level, we recommend the administration and organization of primary health care services under a **District Health System.**

1.30. Full development of the primary health care programme is a long-term process. The principles of primary health care are known; the question is how to put them into practice. On implementation, we recommend a gradual, step-by-step approach. This process should have the support of information, research and evaluation.

1.31. Medical services are expensive and have to be paid for by somebody at some stage, whether in the form of general taxation, compulsory contribution, medical insurance or out-of-pocket expenditure by the user. How the cost of health care services is shared will have an impact on the development of primary health care. With public hospital care being available at highly subsidized charges, people in Hong Kong tend to pay less attention to preventive care and do not take adequate steps to maintain good health. This has resulted in a heavier demand for hospital services.

1.32. Thus, whilst introduction of management reforms in public hospitals by the Hospital Authority and implementation of our proposed measures to improve primary health care will set a new scene in the development of health care services in Hong Kong, it is imperative that a central policy on the future financing of health care services should be formulated. The problems of how health care services should be funded, who should bear the cost and in what proportion should be addressed. We recommend that Government should conduct a special study to contribute to the formulation of this policy.

CHAPTER TWO

PROCEEDINGS OF THE WORKING PARTY

Terms of Reference

2.1. We were appointed by the Governor in August 1989[1] to review primary health care in Hong Kong with the following terms of reference -

(1) To review the present primary health care in Hong Kong with reference to the provision of -

(a) the general out-patient service,

(b) maternal and child health care including family planning,

(c) the school medical service,

(d) health education,

(e) immunization against the major infectious diseases and prevention and control of communicable and non-communicable diseases;

and to review whether there are adequate

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[1] Membership of the Working Party on Primary Health Care is at Appendix 1.

arrangements for co-ordinating the various parts of the service.

(2) Following from (1) above, to advise on measures and changes needed to improve the delivery of primary health care to the public.

(3) To suggest arrangements to strengthen the co-ordination between the out-patient clinics and the hospitals including the issues of keeping patients out of hospitals and encouraging ambulatory care.

(4) To consider whether general out-patient services and any other aspects of primary health care should be brought under the Hospital Authority.

(5) To examine the respective roles of the public and private sectors and the educational bodies with the aim of achieving better co-ordination and co-operation among these sectors in the overall development of primary health care in Hong Kong.

(6) To assess the resource implications required for implementing the recommendations.

Modus Operandi

2.2. The Working Party held 14 meetings and our programme of work can be broadly divided into three stages -

Stage I of the review included collation of information from available sources and through specially commissioned surveys, inviting written submissions from interested organizations, and seeking information from overseas countries including a visit to Singapore.

Stage II of the review included formation of sub-groups for the discussion of specific issues and formulation of recommendations.

Stage III was consideration of the sub-groups' findings and preparation of the Working Party's report.

Written Submissions

2.3. We recognized at the outset that our review should take into account comments and suggestions of groups and professions associated with the delivery of primary health care. Immediately after the first meeting held on 2 August 1989, the Chairman wrote to organizations involved in primary health care including associations of health care professionals and invited them to put forth their views and suggestions on various aspects of our work.

2.4. In response, a total of 38 submissions[2] were received from professional bodies, staff

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[2] A list of all respondents who made submissions to the Working Party is at Appendix 2.

associations, interested groups and individuals. All the comments and suggestions included in these submissions were carefully considered by us. We would like to express our gratitude to all who sent in their submissions.

Surveys and Studies

2.5. Research into operations at various levels of health care and the attitudes of service providers and recipients is an important tool for formulation of new objectives and strategies. This is particularly relevant in respect of the general out-patient service about which so little data are available. As an attempt to fill this information gap, the Working Party commissioned a research team headed by Professor A J HEDLEY, from the Department of Community Medicine of the University of Hong Kong, to conduct a series of surveys on health and medical care in Hong Kong[3]. This included a survey of patients attending Government general out-patient clinics (GOP Survey), another covering a random sample of mother-and-child pairs to examine the patterns of use of maternal and child health services (MCH Survey) and a general health enquiry conducted via a well-population telephone survey (General Population Survey). We are grateful to the research team for its efforts and hard work without which the various reports would not have been available in time for our consideration.

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[3] Hereinafter referred to as the HKU Surveys. A brief summary of the surveys is at Appendix 3.

2.6. The HKU Surveys were supplemented by a survey, conducted by the Department of Health on the opinion of doctors working in the Government general out-patient service and the family health service [4]. The findings have provided us with valuable feedback from front-line staff who have an essential role in improving the quality of service.

2.7. In the course of our deliberations, we also had the benefit of findings and recommendations of consultancy studies on specific issues related to the delivery of primary health care. Amongst these are the Assignment Report on Primary Health Care completed by two consultants to the World Health Organization, Dr John FRY and Dr John MARTIN, the Review of the Public Health Nursing Services in Hong Kong conducted by two nursing experts from the United Kingdom, Miss Heather WILLIAMS and Miss Denise DENNEHY, and the Review on Training in Family Medicine conducted by Dr Wesley FABB, National Director of the Family Medicine Programme of the Royal Australian College of General Practitioners. All these studies were separately conducted at the invitation of the Director of Health.

Local Visits

2.8. To enhance our understanding of the operation of Government clinics and to obtain first-hand information from staff working at these facilities, visits were made to the Lam Tin Polyclinic, the Yau Ma

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[4] A brief summary of this survey is at Appendix 4.

Tei Jockey Club Polyclinic, the Tai O Jockey Club Clinic and the Ngau Tau Kok Clinic. We also visited the Family Practice Units of the University of Hong Kong and The Chinese University of Hong Kong at the Violet Peel Polyclinic and the Lek Yuen Health Centre respectively to learn about the training of medical students in family medicine. These visits have proved to be extremely useful and we would like to express our deep appreciation to all those involved in arranging the visits and briefing us on their work.

<u>Overseas Visits</u>

2.9. At our first meeting on 2 August 1989, we agreed that it would be useful for the Working Party to visit a foreign country especially one whose geographical, demographic and health conditions are similar and comparable to Hong Kong in order to observe the operation of another system of primary health care. This would broaden our vision on the subject and enable a wider consideration of options for the development of primary health care in Hong Kong. Singapore was chosen as the place to visit.

2.10. From 25 February to 1 March 1990, a 14-person delegation, led by the Chairman of the Working Party visited Singapore[5]. The delegation received detailed briefings on the organization and delivery of the various primary health care services and visited a wide range of health institutions. We consider the

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[5] Membership of the delegation and the institutions visited are at Appendices 5 and 6.

visit most fruitful and it has certainly helped us to reflect on the primary health care system in Hong Kong.

2.11. We would like here to express our deep gratitude to the Singapore Ministry of Health for putting together such a constructive programme for us. To Dr KWA Soon Bee, Permanent Secretary (Health)/ Director of Medical Services, and his staff and senior management of the various institutions visited by us, we owe them special thanks for sharing with us their ideas and experience.

2.12. Four members of the Working Party[6] also attended an International Symposium on Health Care Systems held in Taipei from 18-20 December 1989. Although the theme of the symposium was funding of health care services rather than primary health care, the reports from members and the many interesting papers that they brought back with them have provided us with insight into the problems associated with the financial aspects of different health care systems.

Formation of Sub-groups[7]

2.13. At the initial stage of our work, a Statistics Sub-group was formed to oversee the conduct of the surveys, to collate other relevant information and to analyse the statistics collected.

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[6] Professor John C Y LEONG, Dr Anthony NG, Dr Natalis C L YUEN, JP, Miss Mona LO.

[7] Membership of the sub-groups is at Appendix 7.

2.14. At the second stage of the review, in order to consider the issues efficiently, we formed ourselves into four sub-groups, each responsible for examining a particular area of primary health care. These were the Health Promotion and Disease Prevention Sub-group, the School Health Services Sub-group, the Clinic Services Sub-group and the Community Services Sub-group.

2.15. After the sub-groups completed their deliberations and their recommendations were endorsed by the Working Party, a Co-ordinating Sub-group was formed to consolidate the proposals and to draft the report.

2.16. All the sub-groups held a total of 59 meetings and considered some 80 discussion papers. A large number of professionals and experts were co-opted as members of the sub-groups. We would like to thank them for their assistance and contribution.

Format of Report

2.17. This report is the first comprehensive review of primary health care in Hong Kong. For the benefit of those who are not particularly familiar with what primary health care is, we have included in the report a theoretical exposition of the concept and discussions on the importance of primary health care in a health care system. We have also attempted to take stock of the progress made in this area.

2.18. Given the wide range of issues to be addressed in primary health care, it is not possible for us to accord equal treatment to each and every one of them in the course of our deliberations. In this report, we

have chosen to go into considerable detail in respect of those primary health care services which require urgent improvement and others which call for major revamping in order to facilitate implementation. The same treatment is also given to recommendations which are likely to be controversial so that readers are made fully aware of the arguments we have gone through in arriving at a particular decision. In other areas, we have only identified the important principles and discussed them in broad terms.

Acknowledgement

2.19. We are most grateful to the Health and Welfare Branch for providing us with the secretariat for the review. Without the assistance of the secretariat staff, we could not have completed the review in time. Our sincere gratitude also goes to the staff of the Department of Health who have so diligently provided us with information, figures and estimates on the funding and manpower aspects.

CHAPTER THREE

WHAT IS PRIMARY HEALTH CARE

Introduction

3.1. The policy of the World Health Organization is determined by the annual World Health Assembly attended by delegations from all member-states. At the 30th World Health Assembly held in May 1977, it was decided that the main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. This target has come to be popularly known as **'Health for All by the Year 2000'**. In September 1978, the International Conference on Primary Health Care took place at Alma-Ata, the capital of the Kazakh Soviet Socialist Republic. Representatives of 134 nations agreed on the terms of a solemn Declaration pledging urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the peoples of the world. This Declaration states, among the various other terms, that Primary Health Care is the key to achieving the target of 'Health for All by the Year 2000'. It is an approach equally applicable to all countries, from the most to the least developed.

Primary Health Care : the Definition

3.2. Primary Health Care is essential health care made universally accessible to individuals and families

in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community[1].

3.3. Primary Health Care is the first point of contact individuals and the family have with a continuing health care process and constitutes the first level of a health care system. The following are basic features of primary health care as spelt out in the Declaration -

(a) reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

(b) addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

(c) includes at least : education concerning prevailing health problems and the methods of

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[1] Opening statement in the Report of the International Conference on Primary Health Care Alma-Ata 1978. World Health Organization, Geneva.

preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

(d) involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food industry, education, housing, public works, communications and other sectors; and demands the co-ordinated efforts of all those sectors;

(e) requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

(f) should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive importance of comprehensive health care for all, and giving priority to those most in need; and

(g) relies, at local and referral levels, on health workers, including physicians, nurses,

midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Worldwide Developments in the Concept of Primary Health Care after Alma-Ata

3.4. Much has been done by WHO since the Alma-Ata Conference in 1978. Global and regional strategies as well as plans of action have been formulated and disseminated to assist its member-states in the implementation of primary health care as the key to achieving the target of 'Health for All by the Year 2000'. But it remains for the individual country to determine its own detailed approach to primary health care in the light of its overall economic and social development and its method of financing health services.

3.5. There is little doubt that governments in many developed countries have placed increasing emphasis on primary health care in the last ten years. The principal reason for this change is the growing recognition that highly-specialized, advanced medical technology and a hospital-based health care system are most unlikely to be able to promote health care, not to mention their enormous drain on human and financial resources which even the most developed countries have difficulty in providing on an ever-growing basis. On the other hand, there is emerging evidence that a high quality primary health care system is essential for promoting the general health of the population and lays a firm foundation for an efficient and cost-effective secondary and tertiary health care system.

3.6. In the course of individual countries translating the Alma-Ata Declaration into plans of action, the concept of Primary Health Care has been interpreted in three main ways as summarized in the following paragraphs.

Primary Health Care as a Strategy to Health Care

3.7. Primary health care as a strategy to health care has evolved from a recognition that health systems based on high technology medicine, a hierarchy of specialist institutions and fragmented approaches to individual health problems are no longer effective in improving health for all. What is needed is a radical re-orientation of the health delivery system towards building up the infrastructure of a comprehensive health service. In this process of re-orientation, priority has to be given to the development of other sectors such as food supply, sanitation and pollution control and the full involvement of the people themselves. The principles of re-orientation of the health system, intersectoral action and community involvement are essential components of the PHC strategy. Different countries adopt and develop this strategy according to their own political and economic circumstances. The application of the PHC strategy also varies from one country to another depending on their respective stages of development in health care. While some countries attach importance to expanding coverage of basic health care services, others have given more attention to promoting community action.

Primary Health Care as a Level of Health Care

3.8. Primary Health Care is also interpreted to mean a level of health care in the hierarchy of the

health system[2]. In this concept, PHC is the first point of contact between individuals and the health system. It is the base upon which the rest of the health system is being organized. Acceptance of this approach therefore implies that PHC is not only providing preventive and curative care to individuals and families but is also acting as a "gatekeeper" or "protector" of the hospital system, with a view to minimizing pressure on the more expensive and technologically more specialized medical services. For instance, in some developed countries, patients are not permitted access to hospital care without referral by a primary care doctor.

3.9. Unfortunately, to some people, this interpretation of PHC has been mistaken as a cheap and low-cost means to meet the health needs of the community. This has given rise to an erroneous view that primary health care is second-rate care for the underprivileged, an interpretation which is totally at variance with the Alma-Ata Declaration.

3.10. As pointed out by the two WHO consultants in their Assignment Report, "primary health care is not cheap but .... is the only feasible way to improve the health of the population and promote the best use of

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[2] According to the two WHO consultants, there are four essential levels of care in all national health care systems : **self-care** which takes place in the family, **primary professional care** which takes place in the community, **general specialist care** rendered at a district general hospital and **sub/super specialist care** that is usually regionally based serving a wider population.

resources". Acceptance of primary health care as the base of organized health care should be reflected in both national health policies and a shift of resources away from hospitals in favour of primary care services. This is what has taken place in developed countries such as Canada, Australia and those in Europe.

Primary Health Care as a Set of Activities

3.11. The term PHC is also used to refer to a set of activities which are considered to be basic and essential for health. The services provided by primary health care will vary according to the country and the community, but will include at least: promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child care including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; and appropriate treatment for common diseases and injuries.

Primary Health Care in Hong Kong

3.12. The wide range of primary health care services as described in the preceding paragraph is available in Hong Kong. Within the health sector, the Department of Health and the Hospital Services Department together provide a programme of promotive, preventive, curative and rehabilitative services to the people of Hong Kong so as to safeguard and promote the health of the community. These health services, together with developments in other sectors and the general improvement in the socio-economic conditions of the

population, have contributed to the high standard of health now enjoyed by the people of Hong Kong as a whole.

3.13. Despite the existence of primary health care activities, much emphasis in Hong Kong's public sector health care programme has been placed on the development of hospital services in the past two decades. Inadequate attention has been accorded to primary health care and its relationship with medical care at the secondary or tertiary levels. This imbalance in the approach to health care is reflected in the lack of development in the quality and scope of the GOP service which forms a vital part of the primary health care system. It is also borne out by the fact that until very recently, virtually no reference to the promotion of primary health care in pursuit of health for all has been made in any policy statements or public documents on developments in the health programme.

3.14. It is therefore fair to say that while primary health care exists as a set of activities in Hong Kong, the concept of primary health care, either as a strategy to health care or as a fundamental level in the health care system, is underdeveloped in Government's health care policy.

Primary Health Care Services

3.15. In the government sector, PHC services are mainly provided by the Department of Health. These cover the areas of health education, maternal and child health including family planning, immunization and the prevention, treatment and control of diseases. Such services are delivered through a network of clinics and

maternal and child health centres, strategically spread over the territory to ensure easy accessibility, and at an affordable cost. Most of the essential preventive care services are provided free of charge.

3.16. Health education is an important element in promoting health. The Central Health Education Unit is the centralized advisory unit for health education expertise and resources. It maintains close liaison with the mass media and voluntary organizations involved in community health education, and organizes health education activities and publicity campaigns.

3.17. The Family Health Service is responsible for maintaining and promoting the health of women of child-bearing age and children from birth to five years of age. The Service consists of three main areas : Maternal & Child Health, Family Planning and Comprehensive Observation Services. Such services are available and accessible to practically all through 45 MCH centres. For pregnant women, free antenatal and postnatal care, health education as well as delivery service for the multiparous mother are provided. Family planning service is offered in the form of counselling, contraceptive prescription and medical consultation as necessary.

3.18. Free preventive health care services for the infant start from birth with neonatal screening for congenital hypothyroidism and glucose-6-phosphate-dehydrogenase (G6PD) deficiency. At the MCH centres, immunization, physical examination, development observation, child care advice and health education are offered. Preventive health care for young children is further promoted by the extension in November 1988 of

the Hepatitis B Vaccination Programme to all newborns in Hong Kong and introduction since January 1990 of measles, mumps and rubella vaccination for children at the age of one. Free immmunization services are also provided for school children.

3.19. Since Hong Kong is a densely populated city situated in the midst of a region where numerous communicable diseases in both epidemic and endemic forms still exist, continuous efforts have been made in the prevention, surveillance and prompt introduction of control measures against such diseases. This is effected through the various health service units including the regional health offices, the Port Health Service, the Tuberculosis & Chest Service, the Social Hygiene Service and the GOP clinics.

3.20. In the private sector, medical practitioners play an important role in providing the bulk of out-patient medical care service for individual members of the public, mostly on a fee-for-service basis. They are also involved in preventive health care services such as health education and immunization. The January 1989 General Household Survey revealed that while government doctors provided 15.4% of the number of medical consultations to members of the public, the private practitioners catered for 68.6% of the medical consultations.

Conclusion

3.21. The lack of a clear commitment by Government to primary health care has restricted the potential contribution of the many existing health care services to promoting the health of the community. It has also

not facilitated the best use of resources. The appointment of our Working Party is a welcome sign of a shift in emphasis in the health care delivery system. We hope that our recommendations would help to redress the imbalance in the organization of medical services in Hong Kong.

CHAPTER FOUR

OBJECTIVES AND PRINCIPLES

Introduction

4.1. Each country or territory has its own unique tradition and circumstances to be taken into account in developing its health care system. It is imperative that every government should devise its own policies, strategies and plans of action to discharge its responsibilities towards health care for the community. In this chapter, we describe the objectives and principles which have guided the formulation of our recommendations.

Government's Responsibility in Public Health and Medical Care

4.2. The latest available objectives of government policy concerning medical and health services are laid down in the 1974 White Paper The Further Development of Medical and Health Services in Hong Kong. These are -

(a) to safeguard and promote the general public health of the community as a whole; and

(b) to ensure the provision of medical and personal health facilities for the people of Hong Kong, including particularly that large section of the community which relies on subsidized medical attention.

4.3. As hospital services are outside the ambit of our review, we have considered only these objectives in the area of primary health care. In respect of the first objective, remarkable achievements have been made in improving the overall health of our community over the past few decades as reflected in our impressive health indices and our successful control of communicable diseases. No responsible health authority could deny itself the important function to safeguard the public health and promote the health of the community. This policy objective therefore remains valid and important.

4.4. The second objective has been framed in terms so general and with the target population so vaguely defined that as a result, the public sector primary medical service is now providing a highly-subsidized service for all, through an extensive network of GOP clinics. While the provision of a heavily subsidized medical service for those who cannot afford to pay full fees is undoubtedly a suitable policy objective in the absence of some form of national health scheme, the lack of clearly defined target groups and objectives has turned the public sector health care system into one which is passive, reactive, overloaded and isolated from service providers in the non-public sector. The result is Government GOP clinics providing very basic medical care which falls short of the requirements of quality service[1].

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[1] The major shortcomings in primary medical care provided at Government GOP clinics are discussed in detail in Chapter Eight.

4.5. With rising public expectations for better service and the need to promote primary health care, a "public assistance" approach for all in the delivery of personal medical care services seems no longer appropriate.

Objectives

4.6. Throughout our discussions, we were constantly addressing the question of what role Government should play in the delivery and development of primary health care services. We have come to the conclusion that a distinction needs to be drawn between Government's role in public health including promotion of general health of the community and prevention of diseases, and its role as the provider of curative medical services for the individual patient. Earlier, we have acknowledged Government's achievements in public health and re-affirmed its definite role in safeguarding the overall health of the community. In the latter case, we are aware that the Government sector is now taking care of 15% of all out-patient medical consultations, with the bulk being provided by the private sector.

4.7. We therefore recommend that the role of Government in the development of primary health care in Hong Kong should be -

(a) to safeguard the public health of the community and minimize the incidence of preventable disease and disability through provision of quality and efficient preventive care services; and

(b) to ensure the provision of a framework for the delivery of continuing, comprehensive and whole-person medical care to individuals in their home or natural environment.

4.8. Objective (a) re-affirms Government's role in **public health and preventive care** for the population as a whole including such services as control of communicable diseases, immunization, port health, health education, maternal and child health and student health. In this respect, it is widely recognized that health cannot be achieved through the health sector alone. Other closely related sectors also have an important part to play. Many aspects of social and economic development such as education, housing, environmental pollution, sanitation, food and agricultural production, traffic and industrial safety, control of alcohol and drug abuse have an influence on people's health. Primary health care also requires the co-ordinated efforts of government and non-government bodies.

4.9. Objective (b) relates to the provision of **primary medical care** for the individual patient. Government should not and need not aim to become the sole or main provider of such services. The role of Government in this respect should be to ensure that the necessary framework exists for the delivery of quality care to the people of Hong Kong. Having said that, we do not succumb to pressure for the idea that Government should withdraw entirely from the provision of curative medical care at the primary level. There remains a sector of the population who cannot afford to seek treatment from the private sector and whose needs have to be met. Furthermore, in order to promote primary

health care for the entire community, Government has a definite role to play in raising the standard of service in the public sector and interacting with the private sector with a view to improving the standard of private medical practice.

Principles

4.10. In the pursuit of the objectives, we have adopted the following principles -

(a) A Continued Government Presence

Government has the statutory obligation to act as the health authority in maintaining liaison with international bodies such as WHO on international health matters and also in the implementation of statutory health legislation both locally and on an international basis. Public health matters such as immunization, health promotion and prevention of diseases should primarily remain Government's responsibility. Government should also in the immediate future develop quality medical care at the primary level through a network of GOP clinics although the services should be targeted more towards those in need.

(b) Quality Care in Public and Private Sectors

The public sector which currently provides 15% of all out-patient consultations should not become the main provider of these services. However, Government should take

the lead in reforming its GOP service with a view to providing quality, choice and cost-effective primary medical care which will set the standards for the delivery of such services in Hong Kong. Private practitioners have an important role to play. They should be encouraged to adopt the standards set and participate in new schemes of collaboration between the public and private sectors. Such schemes should be devised with a view to raising the standard of practice in the private sector.

(c) Clear Objectives

Clear objectives should be set for each health care function in order to facilitate the evaluation of the service and provide a more rational basis for the allocation of resources. Among these, continuity of care should be regarded as a fundamental objective.

(d) Equity

While individuals and their families have a decided role in taking care of their health needs, no one should be prevented, through lack of means, from obtaining adequate medical treatment.

(e) Cost Containment and Efficient Management of Resources

While subscribing to the principle of cost containment and the use of resources in the

most efficient and effective manner, we should emphasize that investment in primary health care should be considered in the wider context of encouraging ambulatory care on an integrated basis and reducing where appropriate demand for expensive hospital services.

4.11. In addition, we consider that the organization of primary health care in Hong Kong should be based on the following concepts advocated by WHO -

(a) universal coverage of the population with care to be provided according to need;

(b) services should be promotive, preventive, curative and rehabilitative;

(c) services should be effective, culturally acceptable, affordable and manageable;

(d) communities should be involved in the development of services so as to promote self-reliance and reduce dependence, and have an input into the services provided; and

(e) approaches to health should relate to other sectors of development.

4.12. These are the objectives and principles we recommend for the development of primary health care in Hong Kong. In the following chapters, we review the range of promotive, preventive, curative and rehabilitative services, suggest areas for improvement

and discuss matters of manpower training, integration and co-ordination, structure of the system in delivering the service, funding and implementation. Last but not the least, this Report also addresses the wider issues of health economics and sets out our vision for the future delivery of health and medical services in Hong Kong.

CHAPTER FIVE

HEALTH PROMOTION AND DISEASE PREVENTION

Introduction

5.1. Public Health is Public Wealth. The healthier the people, the more likely they are able to contribute to the social and economic development of the territory. It is the responsibility of every government to promote the health of the community and to prevent or minimize the occurrence of diseases. Many prevailing health problems in Hong Kong are susceptible to positive intervention through the promotion of a healthy lifestyle and the avoidance of risk, and early detection and remedies through primary medical care. We are therefore concerned that sufficient emphasis and resources should be directed towards health promotion and disease prevention as in the long run this will mean invaluable savings in health care services.

5.2. Health promotion and disease prevention is a multi-disciplinary, community-based, intersectoral programme. Its success depends very much on the efforts of several sectors including health, education, environment, food hygiene and sanitation and involvement of the public, private and non-government organizations as well as individuals and families. It also covers a wide range of activities. Having regard to our terms of reference, we have confined our discussion mainly to activities which fall within the health sector. This chapter reviews the present

provision of health promotion and preventive care services and examines the respective roles of the various parties with a view to improving the quality of service through better co-ordination.

Health Education

5.3. Health education is an effective means to mobilize public participation which will enable individuals and families to deal with their health problems in the most suitable ways. With proper education and advice, they will be able to take rational decisions in their utilization of medical and health care services. The common practice of many people resorting to some form of self-care, including self-medication, when they experienced health problems points to the importance of appropriate health education[1].

Existing Health Education Activities

5.4. The Central Health Education Unit of the Department of Health carries out health education activities on a target group or project basis, in the form of ad hoc campaigns or on-going activities. It disseminates information to the public in the form of pamphlets, slides, video tapes, talks, exhibitions and

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[1] According to the HKU General Population Survey, among those who had had health problems in the two weeks preceding the interview, self-medication featured prominently as a mode of active self-care. 27% of them had resorted to over-the-counter drugs and 10% had consumed drugs left over from the previous consultation.

through correspondence courses. It plays a co-ordinating, advisory and consultative role in health education and promotion activities which are launched in collaboration with other government or non-government bodies. It also operates a telephone information service on selected health topics and a resource centre providing visitors with materials and information on health education.

5.5. These on-going programmes are regularly reviewed by the Health Education Co-ordinating Committee within the Department of Health which also advises on the major annual programmes and other initiatives. Apart from subject officers in the department, the Committee consists of a representative each from the Education Department, the Hong Kong Medical Association and the Hong Kong Anti-Cancer Society.

5.6. Besides the CHEU, there are other statutory and non-statutory bodies responsible for the promotion of public awareness on specific health issues. These include the Municipal Councils, the Consumer Council, the Hong Kong Council on Smoking and Health, the Occupational Safety and Health Council, the Action Committee Against Narcotics, the Committee on Education and Publicity on AIDS under the Advisory Council on AIDS, the Occupational Health Unit of the Labour Department, the Oral Health Education Unit and the Health Education Unit of the Food Hygiene Section of the Department of Health. Ad hoc health education activities and campaigns are also organized from time to time by district and community organizations, health care professional associations and pharmaceutical and health products companies. Health education is also

incorporated into the curriculum of primary and secondary schools.

Evaluation and Recommendations

5.7. As observed by the two WHO consultants, the Department of Health, through the CHEU, has generally provided "an impressive service which is actively engaged in health promotion". They have however recommended improvements in respect of more effective communication between all health workers and patients, their families and the public at large. In their view, the field of health education could be enlarged to put across the message that there are finite resources within the health sector which have to be used with care to ensure better value for money.

5.8. During the visit to Singapore, the Working Party delegation was briefed in detail on the work of the Training and Health Education Department of the Ministry of Health. Members in particular noted the department's deliberate efforts to use facilitators[2] to deliver the messages of health education and the co-operation between government and

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[2] The facilitators are identified according to target groups -

Target Group	Facilitators
School children	Teachers
Patients	Health care professionals
Employees	Managements and unions
Housewives and the retired	Community leaders and workers

other organizations[3].

5.9. We recommend that the Department of Health particularly its CHEU should continue to play a major and leading role in health education activities taking into consideration the increased recognition of health risks, local morbidity and mortality patterns and the functions of an advisory, co-ordinating and resource centre. Health education activities in respect of objectives, strategy, training, co-ordination and participation of health care professionals should however be improved.

Objectives

5.10. In order to give clear directives to health education providers in the public and private sectors, we recommend that there should be a well-defined policy on health education and promotion which should meet the following targets and objectives -

(a) health promotion is the process of enabling people to increase control over the determinants of health, and to improve their health;

(b) health education is a good basis on which to build a more health conscious and healthier population;

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[3] With the co-operation of the pharmacy trade, pharmacies and drug stores served as non-government outlets for health education materials. Health fairs and nutrition weeks were organized in conjunction with supermarkets and health products companies.

(c) health education should begin at an early age in life;

(d) health education programmes should be specially designed with reference to epidemiological data so as to tackle the major causes of morbidity and mortality; and

(e) health promotion should involve the population as a whole in the context of their everyday life and should not be confined to people whose health is at risk.

Strategy

5.11. We consider that health education conducted by CHEU has so far been oriented towards disease prevention with an insufficient emphasis on health promotion, which is a more effective approach to attain health. We recommend that systematic planning should be adopted for educating the public on healthy lifestyle and self-care which are conducive to both physical and mental health. A proposed health education strategy drawn up for this purpose is at Appendix 8.

5.12. In addition, health education programmes should be targeted towards serious or common health problems. We recommend that priority in health education should be given to -

(a) smoking;

(b) mental health;

(c) alcohol abuse;

(d) AIDS and sexually transmitted diseases;

(e) accidental poisoning and injury;

(f) diet control and healthy eating habits;

(g) regular exercise; and

(h) drug abuse.

These health issues have been identified by drawing reference from local and international publications on determinants of health and have taken into account the morbidity and mortality patterns in Hong Kong. Collaboration with other government departments and those committees referred to in paragraph 5.6 will be necessary in tackling some of these issues. Such intersectoral co-operation is particularly necessary in education with a view to preventing injuries and poisoning arising from domestic, industrial and traffic accidents. Together, they rank fifth in the leading causes of death in Hong Kong and in 1988 alone, accounted for 1 551 deaths and a very considerable proportion of hospital treatment. Emphasis on prevention of accidents through a combination of legislative, educational and publicity measures will minimize the occurrence of preventable disease and disability and achieve savings in health costs.

Manpower and Training

5.13. The CHEU is currently staffed by medical, nursing and general grades staff under the supervision

of a SM&HO. We recommend that the Unit should be re-organized into a specialist service, headed by a person who is knowledgeable in educational principles, communication skills and experienced in research but who does not need to be medically qualified. However, there would still be requirements for medical and nursing input to the work of CHEU. To overcome the present difficulties of the Unit in attracting and retaining these staff, we recommend that more training opportunities such as postgraduate training in health education and training in communication skills should be provided. We further recommend that training programmes should be organized for other health educators and intermediaries such as school teachers, social workers and volunteers.

5.14. The CHEU is equipped with its own set of audio-visual equipment but with production work currently undertaken by nursing staff. To enhance its professional support, we recommend that an audio-visual production team of one Programme Officer, one Assistant Programme Officer and three Technical Officers II should be established in CHEU. This would relieve the medical and nursing staff of technical duties and enable them to concentrate on providing advice or to assume other professional responsibilities.

Co-ordination

5.15. There are many health education activities going on in Hong Kong organized by government and non-government bodies. To ensure better co-ordination, we recommend that membership of the existing Health Education Co-ordinating Committee should be strengthened with stronger representation from public

and private sectors and greater community participation. The strengthened Committee should have the following goals and objectives -

(a) to act as an advisory body to Government on policy matters;

(b) to function as a research and resource centre on health-related data;

(c) to plan health promotion activities to ensure that targeted needs are met;

(d) to co-ordinate the various health education activities in the public and private sectors in order to develop partnership and promote community involvement; and

(e) to set a range of measures for the evaluation of health factors, such as trends in health and disease patterns.

Participation of Health Care Professionals

5.16. People are more receptive to knowledge of health issues and advice on appropriate healthy habits when they are sick. This underlines the important role of health care professionals, in particular doctors, as health educators. In addition to mass campaigns and media programmes on health education, we recommend that health care professionals should be more actively involved in health education. The role of doctors in this respect will be further discussed in Chapter Eight. The CHEU and the Health Education Co-ordinating Committee should act in partnership with the providers

of health care with a view to encouraging patients to be actively involved in the maintenance of their health.

Immunization

5.17. Immunization by the use of vaccines to induce immunity is an effective way of preventing many communicable diseases and in reducing mortality and morbidity among infants and young children. Since the early 1950s, the former Medical and Health Department has introduced various immunization programmes for infants, children and adults. It has evolved into a recommended Immunization Schedule for use in the public sector and for reference by private practitioners[4]. The schedule is regularly reviewed by the Advisory Committee on Immunization and new vaccines and programmes are introduced from time to time within resources available.

5.18. On the whole, we consider that there is a well-developed system with appropriately trained health staff in the Department of Health to ensure an efficient delivery of service. The immunization coverage is very high[5], largely due to the accessibility of the service, success in health education, acceptance of immunization by parents and a well organized delivery system supported by close follow-up of defaulters.

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[4] A summary of the existing Immunization Schedule is at Appendix 9.

[5] The estimated average coverage for BCG and Polio is over 90%.

5.19. As a result of the high immunization coverage, the incidence of the common childhood communicable diseases is low. Diphtheria and poliomyelitis have been virtually eliminated while pertussis and tuberculosis among children remain at a low level[6]. The incidence of measles has also been low except for 1988 when there was an outbreak which affected some 3 000 children, the majority of whom (60%) had no history of measles immunization. This confirmed the cause of the outbreak being the accumulation of susceptible individuals over the years. We recommend that a higher coverage of measles vaccination should be achieved and "mop-up" measles immunization programmes for Primary One school children should be launched to catch those who have missed the standard immunization provided at age one under the programme.

5.20. To maintain its effectiveness, we recommend that the immunization programme should continue to be supported by -

(a) vigilance over defaulters by health staff at MCH centres and regional health offices;

(b) sustained health education efforts to promote the importance of inoculation and vaccination; and

(c) effective data collection and analysis to monitor the morbidity and mortality trends.

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[6] A summary of notification of communicable diseases in Hong Kong by age groups for the years 1984 to 1989 is at Appendix 10.

We also recommend that the immunization schedule should continue to be kept under regular review by the Advisory Committee on Immunization. On the question of chasing up defaulters, we have considered the introduction of a national immunization register as in Singapore including those immunized by the private practitioners. We consider that the new patient-held health booklets to be introduced under the Student Health Service which incorporate the child's MCH records, thereby giving a full immunization record of the child since birth, would serve the purpose[7].

Family Health Service

5.21. The Family Health Service is responsible for maintaining and promoting the health of two vulnerable groups of the population -- women of child-bearing age and children from birth to five years of age. The Service consists of three main areas : Child Health Services including the Comprehensive Observation Service, Maternal Health Services and Family Planning Service. These services are provided at 45 MCH centres and 48 family planning clinics throughout the territory including the outlying islands. Most of these clinics are operating on a part-time basis.

Health Services for Children aged 0 to 5

5.22. Neonatal blood screening for congenital hypothyroidism and glucose-6-phosphate-dehydrogenase

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[7] The proposal of patient-held health booklets is discussed in paragraph 7.49 in Chapter Seven on Student Health Services.

(G6PD) deficiency are carried out immediately after birth. At MCH centres, bathing and dressing of umbilical cord for newborns and regular weighing are provided. Comprehensive health advice in the form of individual counselling, health talks and group discussion are given to parents on child care, child development, nutrition, breastfeeding problems and technique, habit and character training, home safety, prevention of diseases and accidents and the importance of immunization. The importance of regular visits to MCH centre is stressed and detailed progress report is kept for each visit throughout the period. Routine physical examination of newborn babies are made during the initial visit and subsequent visits at two and five years of age. Treatment of minor ailments is available and where necessary the babies are referred to relevant specialist clinics for further assessment and follow-up. Home visits are carried out by nursing staff for newborn babies with special medical problems and defaulters in the immunization programme.

5.23. The Comprehensive Observation Service for all children from birth to five years of age aims to screen, detect and assess early developmental abnormalities among children so as to initiate early remedial treatment and ensure a better chance of rehabilitation. This Service is available at 35 full-time and ten part-time COS Clinics. Health screening and examinations provided to children under the COS are discussed in Chapter Six on Screening Services.

Maternal Health Services

5.24. Apart from antenatal screening activities,

MCH centres provide a comprehensive antenatal care service to pregnant women aimed at maintaining their good health to enable a normal, spontaneous delivery and early identification of high-risk pregnancies so as to provide optimal special care for the mothers and foetuses. The services provided to pregnant mothers include -

(a) complete record of the medical and obstetrical history of individual clients;

(b) complete physical and obstetrical examination and regular supervision and follow-up to enable proper health care and early detection and timely management of high-risk pregnancy;

(c) routine investigation on haemoglobin level, blood group, Rhesus factor and screening for syphilis, Rubella antibodies and Hepatitis B surface antigen. Special investigation is provided as and when necessary;

(d) screening for high-risk pregnancies with referrals to relevant specialist clinics and hospitals for deliveries;

(e) health education in the form of individual counselling and group health talks and family planning advice to ensure better health for mothers and children; and

(f) home visits for cases with special medical problems and those who fail to turn up for routine checks.

5.25. In addition, the Department of Health runs a total of 18 maternity homes for the birth of the second to the fourth child. These maternity homes also receive postnatal referrals, that is, convalescent mothers and newborn babies, from regional hospitals. The maternity homes are currently under-utilized due to the decline in birth rates in Hong Kong and several of them have recently been closed[8]. We recommend that the Department of Health should examine the continuing need for maternity homes having regard to the availability of alternatives for those seeking maternity services so as to redeploy scarce resources, both in terms of funding and manpower, to the new initiatives that we have recommended to enhance the quality of health services.

5.26. Mothers are encouraged to return to MCH centres at about six weeks after delivery for a postnatal check to ensure that their health has recovered to normal. Complete physical and gynaecological examinations are performed by doctors. Health education and counselling on postnatal care, infant care, family planning and prescription of contraceptive devices are also provided. Home visits will be conducted where necessary.

Family Planning Service

5.27. At the family planning clinics, services

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[8] The crude birth rate per 1 000 population in Hong Kong has dropped from 36.0 in 1960 to 12.2 in 1989. A total of 3 722 deliveries took place in all the maternity homes in 1989, accounting for 5.3% of all total live births during the year and representing an overall bed occupancy rate of 23%.

provided include medical examination, counselling on matters related to use of contraceptives and referrals for sterilization and vasectomy. Pap smears are conducted for women over 30 years of age during their annual check-up.

Evaluation and Recommendation

5.28. In the HKU MCH Survey, the general standard of MCH care, in terms of accessibility, affordability and client satisfaction, was rated high by the respondents. The survey also recorded high degrees of preference for government-provided preventive health care activities. The service is patronized by different socio-economic groups in the community.

5.29. On the whole, we consider that the Family Health Service has provided a cost-effective and valuable service to the community and should be regarded as the model for the organization of other preventive care services in the public sector. However, we recommend that the existing service should be improved in the following respects -

(a) for the benefit of children aged 0 to 5 who are at present not covered in the Department of Health's School Dental Service, oral health education and counselling should be provided to parents at MCH centres. As a first step, oral health education should be included in the curriculum of public health nurse training to equip the health nurses working at MCH centres with the necessary knowledge;

(b) to ensure continuity of care, a child's MCH records should be incorporated into the health booklets to be issued to students for their own keeping under the proposed Student Health Service; and

(c) to fill an existing gap in the provision of preventive care services for women, well-woman clinics should be established as part and parcel of the Family Health Service. This proposal is discussed in greater detail in Chapter Six on Screening Services.

<u>Control of Communicable Diseases</u>

5.30. A communicable disease as defined under the Quarantine and Prevention of Diseases Ordinance is statutorily notifiable to the Health Authority. There are 23 diseases as defined under this legislation, which also makes provision for the Health Authority to carry out the necessary investigation into the source of infection, isolation of cases, tracing of contacts and to initiate other preventive and control measures.

5.31. Control of communicable diseases in Hong Kong is currently managed through a wide network of facilities. These facilities include MCH centres, GOP clinics, specialist clinics, accident and emergency departments, and clinics operated by private practitioners which provide means for the surveillance and diagnosis of communicable diseases. Their work is supplemented by government laboratories, regional health offices and hospitals for laboratory diagnosis, isolation, investigation and treatment of contacts and

cases. In addition, the Port Health Service of the Department of Health maintains close vigilance in the control and prevention of communicable diseases.

5.32. Due to the close geographical, similar climate and ethnic factors and the increased movement of people between China and Hong Kong, prompt exchange of epidemiological information is necessary. Hong Kong has, with the assistance of WHO, set up a system of exchange of such information with the southern provinces of China and Macaû for regular updating of the changes in disease pattern and outbreaks of any form of communicable diseases. This channel of communication is most useful and contributes much to the effectiveness of the control of communicable diseases in this part of the region.

5.33. In the control of quarantinable diseases[9] which are included in the list of 23 communicable diseases under the Quarantine and Prevention of Diseases Ordinance, yellow fever poses little danger because of the absence of the specific mosquito vector responsible for transmission locally. As for El tor cholera, a good water supply is important and the prevention and control of cholera have become part of the general programme in the control of diarrhoeal diseases. In the case of plague, vigorous

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[9] Quarantinable diseases are those subject to International Health Regulations under which it is obligatory on the part of any member of the United Nations to report to WHO of the occurrence of the disease in its territory and adopt the prescribed procedures. These are yellow fever, cholera and plague.

anti-plague measures against rodents and their fleas in accordance with the International Health Regulations are imposed on immigrants or visitors from any country which is listed by WHO as being infected by this disease. However, since the classic epidemic host and vector are present in large numbers in ports and urban areas, Hong Kong is a highly receptive area for the plague bacillus. The primary objective of Hong Kong's anti-plague measure is to prevent the introduction of this highly dangerous infectious disease, to rapidly detect plague activity in man and to rapidly control and eradicate the organisms from the territory.

5.34. Apart from the three quarantinable diseases mentioned above, other communicable diseases which are also classified as notifiable diseases are by and large endemic with low mortality and morbidity. Because of the preventive and control mechanism that has been established over the years, these will not in normal circumstances assume epidemic proportion. For example, the common childhood communicable diseases such as diphtheria, measles, whooping cough, tetanus and poliomyelitis are either eradicated or well under control. The mortality rate for tuberculosis has shown a steady decline although it remains to be a cause for concern[10].

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[10] At an incidence rate of about 120 per 100 000 population and with about 7 000 new cases reported every year, tuberculosis is still a public health problem. We are aware that the Department of Health has commissioned two experts to advise on measures to improve the TB control programme.

5.35. Another communicable disease of concern in Hong Kong is Viral Hepatitis. In Hong Kong both Type A and Type B viral hepatitis occur endemically with periodic outbreaks of hepatitis A. For the prevention of hepatitis B infection, disposable syringes and needles have been used in hospitals, clinics and vaccination programmes in Hong Kong more than a decade ago and screening of donated blood for hepatitis B antigen has been a standard procedure since 1975. A Hepatitis B Vaccination Programme was introduced in 1983 for newborns of carrier mothers and health care workers who are in frequent contact with blood and body fluids. This programme has been extended to cover all newborns since 15 November 1988.

5.36. Other communicable diseases of public health importance which are not defined under the Quarantine and Prevention of Disease Ordinance are AIDS, sexually transmitted diseases and influenza.

5.37. The incidence of AIDS has been increasing and a total of 42 cases has been reported up to the end of September 1990. In the absence of effective cure, we agree that education and publicity should be emphasized in the prevention of AIDS. An Advisory Council on AIDS was established in March 1990 to replace the former Expert Committee on AIDS.

5.38. Free medical consultation, advice and investigation for patients suffering from sexually transmitted diseases are provided under the Department of Health's Social Hygiene Service. Special efforts are made on health education, contact tracing, follow-up of defaulters and those at risk of frequent

exposure. The incidence of syphilis continues to drop while gonorrhoea, non-gonococcal urethritis and non-specific genital infection constitute the majority of cases.

5.39. In the case of influenza, the Virus Unit of the Department of Health has been designated by WHO as the National Influenza Centre. The Unit works closely with the WHO International Influenza Centres in the UK and USA. The Department of Health has designated 11 GOP clinics throughout the territory to report on a weekly basis the number of influenza and influenza-like illnesses to the Statistical Unit of the department. Virological investigations of throat and nasal swabs are examined by the Virus Unit and laboratory data of virus isolation and serological diagnosis are sent to the WHO International Centres for further investigation.

Evaluation and Recommendations

5.40. We consider that the existing mechanism for the control of communicable diseases to be effective. However, Hong Kong is a densely populated city situated in a region where numerous communicable diseases in both epidemic and endemic forms still exist and there is a heavy load of international travellers and refugees and illegal immigrants arriving in large numbers. A high degree of vigilance and continuous efforts on control of communicable diseases should therefore be maintained. While the surveillance network built up over the years should continue, we recommend that the system be strengthened in a number of ways -

(a) the communicable disease notification form (MD 1) should be updated, improved and simplified to facilitate notifications. It is noted that while private practitioners are providing some 70% of all out-patient medical consultations, only about 10% of notifications are made by them;

(b) an epidemiological bulletin should be introduced by the Department of Health to improve communication with all medical practitioners, to enable the transmission of data to them and to encourage their response. The bulletin should include a vigorous approach to the analysis and interpretation of current trends and their implications; and

(c) the epidemiology unit within the Department of Health should be strengthened to take on the new responsibilities as mentioned in (b) above.

5.41. We have considered whether AIDS should be included in the list of notifiable diseases in order to improve control by tracing the source of infection and contacts. Having regard to the social and cultural implications and the possibility that mandatory notification might discourage patients from seeking medical care, we agree that the current voluntary notification of AIDS should continue.

Control of Non-communicable Diseases

5.42. Control of non-communicable diseases relies on three levels of prevention : primary, secondary and tertiary prevention. On primary prevention, we have discussed under Health Education those non-communicable diseases which are prevalent in Hong Kong and have included them as priority areas in health education. Secondary prevention involves the detection of diseases at an early stage so that curative treatment can be given promptly. Health screening conducted appropriately is an effective means of secondary prevention. The screening programmes for specific target groups and our recommended improvements to existing screening services are discussed in Chapter Six. Tertiary prevention is to reduce sequelae and further deterioration of established diseases at an advanced stage. Rehabilitation including both medical and social rehabilitation is the mainstay in tertiary prevention. This will be addressed in Chapter Nine on Community Health Services and Rehabilitative Care.

Occupational Health

5.43. Hong Kong has a dynamic workforce of 2.8 million people. Promotion of occupational health is not only beneficial to the individual worker but is a constructive factor contributing to economic development. It is a mission for government and health care workers as well as employers and trade unions. We consider occupational health as an essential component of primary health care but a comprehensive review of this important subject would not be possible without

the input from the other relevant parties[11]. Since the last comprehensive review of the occupational health services in Hong Kong was conducted in 1976 by a consultant from the United Kingdom, we recommend that it is timely to carry out another overall review taking into account changing practices in industry and the modern day concepts of occupational health.

5.44. This section briefly reviews the provision of occupational health services in Hong Kong and suggest certain areas for improvement.

5.45. The term "Occupational Health Services" as defined under Article 1 of the Occupational Health Services Convention (No. 161) of the International Labour Conference means services entrusted with essentially preventive functions and responsible for advising the employer, the workers and their representatives in the undertaking on -

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[11] The Labour Department assumes overall jurisdiction for the policy and strategy on the promotion of occupational health and safety. Through its Occupational Health Division and Factory Inspectorate Division, it is responsible for supervising health standards and practices in industry. The department also administers legislation on employees' compensation including compensation in respect of injuries and deaths caused by occupational diseases. The **Occupational Safety and Health Council,** a statutory body set up in 1988, aims to promote a safer and healthier working environment through programmed activities for education and training. Trade unions and employers associations also play an important role in occupational health matters.

(a) the requirement for establishing and maintaining a safe and healthy working environment which will facilitate optimal physical and mental health in relation to work; and

(b) the adaptation of work to the capabilities of workers in the light of their state of physical and mental health.

In Hong Kong, the Occupational Health Division of the Labour Department manned by medical and nursing staff seconded from the Department of Health provides advisory and consultation services to the public on matters concerning the health of employees and the hygiene of workplaces. The aims of the service are to preserve the health of employees, prevent occupational diseases and promote occupational health.

5.46. A major responsibility of the division is to investigate notified occupational diseases and potential health hazards reported by the Factory Inspectorate and to determine preventive action. It also carries out medical examinations of persons exposed to certain potential work hazards and handles medical clearance for employees' compensation cases. In respect of occupational health promotion and education, the division regularly organizes seminars, exhibitions to alert employers and employees to occupational hazards in the workplace. Booklets and codes of practice on the prevention of occupational diseases are also published and distributed. Its work is supplemented by surveys in various industries and epidemiological studies on health and hygiene conditions in the workplace. Partly because of the

small size of most of the undertakings in Hong Kong and partly because it is not a statutory requirement, provision of occupational health services or appointment of an occupational safety officer in the workplace is not a common practice in Hong Kong[12].

5.47. To improve the occupational health of Hong Kong's workforce, we recommend that the following areas deserve particular attention -

(a) employers should be encouraged to provide occupational health services in the workplace. For small establishments, they could resort to occupational health group practices whereby the services would be contracted out to medical institutions or private practitioners through the respective trade associations;

(b) primary care doctors should be encouraged to orientate their practice to put greater emphasis on the occupational history of their patients, to ensure that this is properly recorded and to provide basic occupational health services to facilitate early identification and notification of occupational diseases. This would generate

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[12] There are about 20 firms employing some 50 full-time nurses in occupational health. Some of them have also engaged the service of part-time doctors. The practice of occupational health in these establishments is largely confined to the clinical aspects and first aid rather than the full scope of occupational health which lays emphasis on promoting and conserving the health of employees.

epidemiological data and help to build an effective surveillance system for the monitoring of occupational diseases. In this respect, the Labour Department should carry out publicity targeted towards the doctors to encourage them to notify occupational diseases. The HKCGP and the medical associations can help disseminate information on occupational diseases to members of the medical profession;

(c) doctors participating in medical care schemes for employees should be trained to provide occupational health services, with help and advice from trained staff in the Occupational Health Division. At present, the involvement of most of these doctors is confined to clinical treatment;

(d) in addition to diploma courses in occupational medicine and occupational health nursing now available at The Chinese University of Hong Kong, more training opportunities on occupational health services should be provided for health care professionals, workers and management. The Department of Health should explore the possibility of organizing courses with local tertiary educational institutes, preferably with the participation of the private sector;

(e) training opportunities, grade structure and promotion prospects of occupational health doctors, hygienists and nurses in the Occupational Health Division should be

reviewed and improved so as to solve the problem of deploying and retaining staff there;

(f) workers should be encouraged to take a more active part in promoting healthy working environments and working conditions for themselves and the public at large should be educated on the importance of occupational health; and

(g) while legislative and other measures to ensure the provision of a safe working environment are pursued by the Labour Department in its strategy to promote occupational health and safety, greater attention should be given to the medical and health aspects. This could be achieved by strengthening co-ordination between the Labour Department and the Department of Health and closer liaison between the Occupational Health Division and hospitals and clinics offering remedial treatment to persons suffering from occupational diseases.

Mental Health

5.48. One category of diseases which is becoming more prevalent in modern society characterized by intense competition and stress is mental diseases of all kinds. The most likely times for mental illness to develop are puberty, pregnancy, menopause, late middle age and retirement. We have considered and agreed that it is not practical to screen for mental illness in a generalized manner. Instead, doctors, nurses, social

workers, health visitors, teachers, family members and friends should be made aware of the possible occurrence of the diseases and ensure that proper advice and counselling is being rendered.

5.49. While control of mental diseases is equally important at the three levels of prevention - primary, secondary and tertiary[13], here we have placed particular emphasis on aspects of primary prevention. We recommend that promotion of mental health should be strengthened. Health education should be enhanced to increase public awareness of common mental health problems and to prevent the onset of disease. This is particularly relevant at a time in Hong Kong when people are being exposed to increasing stress arising from political uncertainties in approaching 1997 and a possible slow down in economic development. Such educational programmes should also aim at correcting public misconceptions about mental problems and minimizing society's prejudice against mental patients.

5.50. We have noted that among patients with mental problems, less than 5% are psychotic cases. The majority is suffering from minor mental disorders usually caused by psycho-social problems. Early detection of these disorders and provision of appropriate care at a primary health care setting would significantly prevent their deterioration and in turn lessen the demand for specialist services. It is therefore highly desirable that primary care doctors should possess skills to detect and manage minor psychiatric problems and refer the serious cases to

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[13] See paragraph 5.42.

psychiatrists. Under the whole-person care approach in the practice of family medicine, primary care doctors should be able to detect and deal with minor mental problems. We recommend that mental health education should be strengthened both at the undergraduate and postgraduate level in medical education, particularly in vocational training in family medicine.

Health Information System

5.51. As observed by the two WHO consultants, "there is a remarkable lack of information about the health status of the population. This appears to be a major reason for the failure of the services to respond to major demographic and epidemiological changes. They have got 'stuck' in the past." Whether in health or other programmes, information and the proper use of it in planning and evaluation of services will ensure the efficient use of resources and achieve the best results.

5.52. The health information vacuum referred to by the WHO consultants exists partially at the territory-wide level but is more evident at the clinic or practice level. At the territory-wide level, currently available health information comprises too many statistics with too little interpretation in terms of public health. Vital statistics including birth and death rates, morbidity and mortality patterns and life expectancy figures are updated and published regularly to reflect the health status of the population and for the purposes of international comparison. Statistics on the provision and utilization of services also form an important part of the available data, very often perceived as performance indicators or achievement of certain declared objectives. However, insufficient use

has been made of such health information for policy formulation and the planning of services in the health programme as well as other services such as housing, community services and environmental protection.

5.53. At the clinic or practice level, the lack of comprehensive information about a patient's medical history and health status has hampered the provision of continuity of care, the development of a close doctor-patient relationship and the adoption of more appropriate treatment protocols. The issue of poor quality medical records now maintained at the Government GOP clinics and similar problems in private practices are addressed in Chapter Eight on Clinic Services.

5.54. We have recognized at the very beginning of our review the need for health information. The ad hoc surveys commissioned by the Working Party were an expedient measure to fill the prevailing information gap. We are fully convinced that a systematic approach to develop a health information system in Hong Kong is long overdue. We recommend that collection, analysis and utilization of information about health should be substantially improved. This information system should develop at several levels.

(i) Health information at the territory-wide or community level

5.55. The development of a health information database is necessary at a territory-wide or community level to support the operational strategies of the Department of Health and to determine priorities in health care programmes. Such data should include the general health status of the population in terms of

vital health statistics, the changing disease patterns, the impact of social and environmental conditions on community health and utilization of existing health services and resources. A small team comprising members of the Working Party and professional experts had given consideration to the role of health indicators in the development of a territory-wide health information system and had recommended that health indicators should be developed in Hong Kong.

5.56. Health indicators are reliable, quantifiable and valid measures of health risks, health status, utilization of health care services and health outcomes of individuals and population groups in a community. They are useful in identifying health problems upon which specific targets of health intervention can be set and delivery of health care services planned accordingly. Despite the fact that health indicators have been set at a global, regional or national level[14], we consider that Hong Kong should develop

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[14] Global indicators in respect of 'Health For All By the Year 2000' include for instance an infant mortality rate below 50 per 1 000, a life expectancy of over 60 years, readily available primary health care such as immunization against six key childhood diseases. The WHO European Region has developed 38 targets for the attainment of health. For example, on infant mortality and life expectancy at birth, the WHO European Region's targets are less than 20 per 1 000 live births and at least 75 years by the year 2000. In the UK and USA, the public health service has developed health strategy targets with specific objectives which are translated into measurable defined outcomes. For instance, indicators such as life expectancy at birth of 78 years and infant mortality of no more than 7 per 1 000 live births by the year 2000 are proposed in the <u>US Promoting Health/Preventing Disease Year 2000 Objectives for the Nation</u> which updates previous targets set for the year 1990.

its own set of health indicators or targets based on local conditions. Conventional health indices will, however, continue to be compiled for international comparison purposes and as an indication of the health of the population as a whole. The preferred approach and methodology to construct health indicators in Hong Kong should include -

(a) the formation of a multi-disciplinary steering group which should be responsible for the initial statement on priorities and the overall strategies required to achieve the expected health outcomes. The task of defining specific objectives and quantifying targets for each priority area could be delegated to specialist working panels. In formulating these specific targets, consideration should be given to the prevailing social, economic, environmental and health factors which are relevant to the attainment of the goals;

(b) the conduct of small area analysis in order to compare the incidence of health problems or the prevalence of specific health characteristics between different geographical areas which may vary according to the social and economic circumstances of the population living in the area, the environmental conditions and the provision of health and medical services. In Hong Kong, such small area analyses could best take place in each administrative district with full community participation; and

(c) the establishment of a register of health and health service studies to monitor all available sources of health-related intelligence which may contribute to the development and use of indicators.

(ii) Health information at the **service** level

5.57. The cost-effectiveness and quality of health services should be subject to regular evaluation in which information is an indispensable tool. We consider that each service division, whether in health education, control of communicable diseases or the student health services, should have built-in capacity and resources to conduct research and surveys. Collaboration with the universities, medical associations and private practitioners should be encouraged and the findings of these studies should be made publicly available.

(iii) Health information at the **clinic or practice** level

5.58. As revealed by the HKU GOP Survey, the contents of medical consultations in a clinic is the key source of data which can be fruitfully utilized to initiate changes both in terms of service management and professional practice. Unfortunately, until the introduction of medical records for individual patients at four GOP clinics recently, most of these data have been lost or neglected. As a result, the GOP service has "got 'stuck' in the past" and has failed to adapt itself to changing needs.

5.59. To rectify the situation, we recommend that a computer-based clinical information system should be

developed in the GOP service. The purpose of a clinical information system is to store data on individual patients and, from this, to produce clinical information to support the management of the patient's condition and to provide administrative information to help in the management of resources. The implementation of this system would promote continuity of care, provide professional satisfaction to doctors in GOP clinics who could then initiate appropriate treatment for individual patients and facilitate health services research and continuing education. In the long run, it would enable the better management of resources in the clinic and provide opportunities for re-allocation of resources to best meet the needs of the service.

5.60. We are aware of ongoing discussions between the Department of Health and a HKU research team on a proposed three-year programme for the development of a clinical information system in the GOP service. We <u>recommend</u> that this proposed programme should commence as soon as possible.

A Health Information Unit

5.61. To improve the collection and analysis of health information and to undertake the various new initiatives mentioned in this section, we <u>recommend</u> that the present Statistical Unit in the Department of Health should be strengthened and expanded to become a Health Information Unit. This Unit should also undertake research in primary health care in conjunction with the universities, the HKCGP and other medical associations. It should also devise and implement a mechanism for the dissemination of health

information and findings of health service research to health care professionals and members of the public. One example is the epidemiological bulletin that we have recommended in paragraph 5.40(b).

Conclusion

5.62. This chapter has extensively reviewed health promotion and preventive care services the importance and contribution of which to the health of the population have so often been taken for granted. While acknowledging that there are resource constraints in the medical and health programme, the emphasis and resources devoted to health promotion and preventive care will help to contain health costs in the long run. We would like to reiterate that success in health promotion and disease prevention depends very much on the efforts and co-operation of the other policy arms of Government such as in the programmes on education, labour, environmental protection, municipal services, social welfare as well as the acceptance of responsibility by individuals, families and the community. We hope that our deliberations in the report on this important area would receive the enthusiastic support of the parties concerned.

CHAPTER SIX

SCREENING SERVICES

Introduction

6.1. Health screening helps to detect the disease early so as to facilitate treatment to be promptly provided and to forestall the disease from worsening. This would ensure a healthier population while at the same time minimize the cost of medical treatment in primary and specialist health care. Different screening programmes for specific target groups are already being provided in the primary health care services delivered by the public sector. This chapter discusses the broad principles for health screening programmes, reviews the existing screening services, proposes new initiatives and examines the role of Government and other sectors.

6.2. We have defined screening as the presumptive identification of unrecognized disease or defect by the application of simple tests, examination or other procedures. Screening tests are valuable means which sort out apparently well persons who probably have a disease from those who probably do not. Appropriate treatment could then be promptly prescribed.

6.3. Health screening programmes can be conducted in the form of mass screening or opportunistic screening. **Mass screening** is the application of tests or other examination procedures to unselected individuals within a defined population group, for example, women of a certain age group or the elderly

above a particular age, through a system of call and recall. **Opportunistic screening** is carried out in a clinic setting when doctors, especially those at the primary care level, apply screening tests during normal consultations to patients who come to see them for other health problems. Identification of patients for screening procedures in this context is usually prompted by the patient's current health status, his medical history, occupation and a combination of other factors. It is not always necessary for the attending doctor himself to carry out the screening procedures; he may refer or advise his patient to obtain the service elsewhere.

Cost-effectiveness of Mass Health Screening

6.4. While health screening is generally an effective means to detect the occurrence of disease, we consider that the following principles should be observed, particularly in contemplating any mass screening programmes -

(a) not every disease can be screened and not every investigation can be used as a screening test;

(b) screening programmes should be cost-effective and high-yield in terms of detection of diseases: they should be epidemiologically validated and linked to the risk of morbidity in different population sub-groups;

(c) screening programmes should be confined to diseases which are important causes of morbidity and mortality;

(d) screening for specific target groups rather than general screening on a population-wide basis would be a more effective use of resources;

(e) periodical screening at prescribed intervals such as at various stages of a child's development would be more effective than frequent screening at regular intervals, say, on an annual basis;

(f) facilities and resources must be available for the diagnosis and treatment of disorders identified in the screening procedure and the disorder screened must be amenable to treatment; and

(g) massive screening programmes which are conducted without due regard to the above factors could be counter-productive in terms of creating anxiety among patients to be screened, exerting undue pressure upon medical services and thus depriving those genuinely in need of an opportunity for early treatment.

6.5. We have pointed out in Chapter Five that the present delivery and planning of health care services in Hong Kong are hampered by the limited availability of health information. Without a detailed and comprehensive epidemiological analysis of the health status and health problems of the population, it would not be meaningful to introduce mass screening programmes for all on a territory-wide basis. We therefore <u>recommend</u> that in the local context, screening programmes targeted towards diseases or

population sub-groups should be more cost-effective than general population screening. In addition, different approaches should be adopted for different target groups in the provision of screening services.

Screening Programmes

6.6. We have looked into the need for and benefits of screening for different population sub-groups. We began by reviewing existing screening activities in Hong Kong notably those provided by the public sector which can be categorized under various life stages : pregnancy, infancy, childhood and adulthood.

Screening for Women of Child-bearing Age and Newborns

6.7. The Family Health Service of the Department of Health provides a range of health screening services to women of child-bearing age and newborns at MCH centres. The services available include -

(a) Antenatal and Postnatal Screening

For pregnant women, antenatal screening and prenatal diagnosis are available for high-risk or common defects and abnormalities, such as neural tube defects for the non-Chinese women who are the high-risk group and chromosomal abnormality for women over 35 years of age and those with previous children having chromosomal abnormality. The diagnostic techniques include amniocentesis, chorionic villus biopsy, foetal blood sampling and ultrasound. Antenatal care services including complete physical and obstetrical

examinations for early detection and management of high-risk pregnancy, routine investigation including haemoglobin level, blood group, Rhesus factor, screening for syphilis, rubella antibodies and Hepatitis B surface antigen are also performed. After delivery, mothers are encouraged to return to MCH centres for postnatal check-ups during which complete physical and gynaecological examinations are performed.

(b) Physical Examination and Screening of Biochemical Disorders in Newborns

In order to promote optimal health and development, health screening and physical examination begin at the very early stage of life immediately after birth. At present, two biochemical disorders in newborns which occur frequently in Hong Kong are routinely screened for: (a) glucose-6-phosphate-dehydrogenase (G6PD) deficiency occurring in 4.13% of males and 0.33% of females; and (b) congenital hypothroidism occurring in 1 : 3 030 births. All newborn babies are covered in the Combined Neonatal Screening Programme in the Clinical Genetic Service of the Department of Health. Routine physical examinations are also offered to newborn babies during the initial visit to MCH centres shortly after birth.

(c) Family Planning Service

Family planning service is made available to women of child-bearing age at several stages,

including antepartum and postpartum periods. Besides educating and promoting family planning and providing means of birth control, medical examination and cervical cytology screening during annual check-up for women over 30 years of age are also available. Family planning service including health screening is also actively promoted by the Hong Kong Family Planning Association subvented by Government.

Except for a nominal attendance fee of $1 at the Government family planning clinics, all the above services are provided free of charge.

6.8. The various screening programmes for antenatal and postnatal care and for neonates are generally effective and are providing a useful service to the community. However, we have identified a gap in the existing screening services for women. At MCH centres, women attending for antenatal and postnatal care receive other screening tests such as blood pressure measurement to detect hypertension, breast examination and urine examination for diabetes mellitus. Women attending the family planning clinics are provided with medical examination and cervical cytology service. However, women who fall outside the client groups of these facilities, such as menopausal women, women who have been sterilized or unmarried women, are not being cared for. The only service available to them is the cervical cytology screening programme which offers cervical smears to women over the age of 30 at four selected MCH centres.

6.9. During its visit to Singapore, the Working Party delegation was impressed by the range of

promotive and preventive health services operated there for women of all ages. In the well-woman clinic located in Singapore's polyclinics, special services including general medical check-up, screening for cancers of the cervix and breast, high blood pressure and diabetes mellitus are provided to the attending women at a charge. We consider that women in Hong Kong have the same health needs as their counterparts in Singapore. To provide preventive health service to women of all ages, we recommend that well-woman clinics should be set up as part and parcel of the Family Health Service. As a first step, we recommend that such services should be provided on a pilot basis at two MCH centres.

6.10. In well-woman clinics, emphasis should be placed on health education and counselling for women as a means of health promotion and maintenance. Health screening programmes for the early detection of serious health problems and diseases should be provided. The latter should be planned according to the principles of screening including cost-effectiveness. These should include general medical examination carried out at periodical or prescribed intervals, rubella antibody screening and rubella vaccination for women who plan to become pregnant rather than being confined to a certain age group, screening for diabetes mellitus for those aged 45 and above by testing urine annually for sugar, periodic cervical cytology screening for women who are sexually active and not necessarily confined to those aged 30 and above. Screening for carcinoma of breast at prescribed intervals and education on breast self-examination should cover all women. Screening for hypertension by regular but not necessarily frequent blood pressure measurement should be included in the service offered.

6.11. We expect queries or criticisms as to why women groups should be a target for screening activities. We consider well-woman screening to be justified on the grounds that in Hong Kong, malignant neoplasm is the leading cause of death and in the female population, cancer of breast and cancer of cervix rank second and sixth as causes of death due to cancers. These diseases may be prevented or diagnosed early by screening tests and health education. Moreover, women have an important role to play in health promotion and care in the family and the emphasis on health education and counselling in well-woman clinics would enable them to better discharge their functions.

Screening for Pre-school Children

6.12. Under the Family Health Service of the Department of Health the following programmed services for the 0-5 age group are available at MCH centres which aim to screen, detect and assess early developmental abnormalities among children so as to initiate early remedial treatment and rehabilitation -

(a) periodic physical examination; and

(b) Comprehensive Observation Scheme.

Under the COS, children are offered periodic screening tests at the age of ten weeks, nine months and three years, for gross motor and posture development, fine manipulation, hearing and language, social and adaptive behaviour, vision, head circumference, body weight and body length measurement. Special observation is made for abnormal or at-risk infants. Cases with suspected defects are referred to the appropriate specialist

clinics and Child Assessment Centres for diagnosis, treatment and follow-up supervision.

6.13. This service is highly commended by the WHO consultants and is well received by parents.

Screening for Students

6.14. The current provision of health and medical services to school children will be thoroughly reviewed and discussed in Chapter Seven on Student Health Services. We have concluded in that review that a comprehensive and co-ordinated health screening programme for students is urgently required.

Occupational Health-related Screening

6.15. The Occupational Health Division of the Labour Department carries out medical examinations of personnel exposed to ionizing radiation, users of compressed-air breathing apparatus, and of government employees engaged in diving or pest control or working in compressed air[1]. The aim is to ensure early detection of any diseases associated with such occupational hazards and to institute treatment promptly. Occupational Health Officers are also engaged in the medical assessment of air traffic control officers, professional air crew and private

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[1] In 1989, 1 041 medical examinations of workers exposed to these hazards were conducted.

plane pilots to ensure compliance with international aviation standards[2].

Screening for Employees

6.16. Pre-employment medical examinations in private and public sectors provide another opportunity for screening. The examination usually includes blood pressure measurement, urine tests, chest X-ray and general examination. If necessary, tests for colour blindness and visual acuity are also carried out. The Medical Examination Board of the Department of Health is responsible for examination of all applicants for civil service jobs prior to appointment, while private practitioners are engaged either on a fee-for-service or contract basis to perform such examinations for companies and various establishments in the private sector. Some private corporations also provide regular medical check-up for their staff as part of the medical benefits package.

Screening for the Elderly

6.17. Despite the well acknowledged health needs of the elderly, their heavy demand on the existing hospital and clinic services and the ageing of Hong Kong's population, there is no comprehensive preventive health care programme for the elderly. The emphasis so far has been on educating the elderly to a healthy lifestyle and stressing the importance of early

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[2] In 1989, 244 such assessments were made.

treatment of diseases. Health screening programmes for the elderly are available in a number of social welfare agencies which are actively involved in elderly services.

6.18. In line with the broad principles for screening, we do not consider it desirable to advocate at this stage a massive screening programme for all elderly people above a certain age. Old people are prone to a great variety of diseases which are related to their medical history, living environment and other social and economic factors. Their individual needs should best be looked after by their primary care doctors. Referral for screening and investigations should be part and parcel of good family medicine which we strongly feel should be developed in both public and private out-patient care. We therefore recommend the introduction of opportunistic screening for the elderly aged 65 and above attending GOP clinics. The HKU GOP Survey showed that 21.5% of those attending these clinics were the elderly aged 65 and above, a proportion higher than the general population. These patients were also found to be poorer, less well educated and hence more in need of preventive health services. Such screening activities should be primarily aimed at detecting diseases which are prevalent in the aged and which will lead to a serious sequelae if not treated at an early stage. These diseases include hypertension, diabetes mellitus, eye diseases, mental diseases, chronic respiratory diseases and musculo-skeletal problems. The screening programme would include simple history taking, measurement of blood pressure, examination of urine, test of vision and hearing. If abnormalities are detected, referral to relevant specialties would be made.

Screening for Other Adult Groups

6.19. Having regard to the mortality data in Hong Kong[3], we recommend that consideration should also be given to the introduction of opportunistic screening for patients attending GOP clinics who are aged 45 to 64. These people should be screened for diseases not necessarily related to the health problem leading them to seek clinic service such as cough and cold.

6.20. Under this approach, the doctors at the clinics would, by making reference to the health status and medical record of patients, identify targets for screening and the tests required. Such screening could consist of some procedures and laboratory tests to be delivered by specially trained nurses. This might involve making reference to the family and social history of the patient, physical examination on height, weight, blood pressure, breast examination, simple laboratory tests which may include urine analysis and health education to promote knowledge of health and disease and healthy lifestyle.

The Role of Government and Other Sectors

6.21. As can be seen from above, Government is already providing screening services of varying degrees of coverage. The services provided reflect Government's commitment in the promotion of public

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[3] A summary of mortality data in Hong Kong for the year 1988 is at Appendix 11.

health and has contributed significantly to some of Hong Kong's impressive health indices, such as low infant mortality and maternal mortality rates. We recommend that the existing screening programmes for women of child-bearing age, newborns and pre-school children should continue and a comprehensive screening programme for school children under the new Student Health Service be introduced.

6.22. Any further expansion of Government provision of screening programmes should, however, take into account the following factors -

(a) screening services especially for well persons should not be provided as an isolated programme, but should be regarded as a component of good family practice at the primary medical care level;

(b) Government provision of additional health screening programmes as an "available for all" service may not be justified, at least at this point in time when there are inadequate information on the health needs of the population and other priority areas to be tackled;

(c) the success of a Government-run free or heavily subsidized screening service could lead to demands for the service to be made universally available and generate increased pressure on Government's finite resources; and

(d) health maintenance such as for the elderly requires a multi-factorial approach and it

will not be sufficient to provide a screening programme without tackling the other aspects such as social support, environment, housing and mobility.

6.23. In the light of the above considerations, we recommend that new initiatives in this area should be built on the existing infrastructure in order to bridge an obvious gap in screening services and to strengthen health promotion and disease prevention for certain specific groups. These include well-woman screening at MCH centres and opportunistic screening for the elderly and those aged 45 to 64 attending GOP clinics.

6.24. Apart from Government, other parties have a role to play in promoting health screening. Employers should be encouraged to provide screening as part of the pre-employment medical examination, and regular follow-up screening as part of employment benefits. Since Government itself is the biggest employer in Hong Kong, it should assume a leading role. Insurance companies should provide regular health screening for their policy holders as part of the insurance schemes. Private practitioners should be encouraged to practise anticipatory medicine[4] and in the course of their

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[4] Anticipatory Medicine is a term used to describe medical practice providing anticipatory care to patients. It provides health promotion and maintenance, disease prevention and cure, as health activities complementary to each other, averting the danger of polarization of attitudes and activities between prevention on the one hand and treatment on the other.

practice, to carry out opportunistic screening and to promote awareness of health among their patients. Appropriate screening activities could also be included in the scope of service to be provided at public clinics contracted out to groups of doctors in the non-government sector as discussed in Chapter Eight.

Implementation and Evaluation of Screening Programmes

6.25. We recommend that the proposed new initiatives should be conducted on a pilot basis linked to a detailed evaluation plan designed to assess the costs and benefits of this approach compared to other options for providing preventive health care. We further recommend that expert working groups should be set up to design the details of each of the various screening services, the appropriate screening protocols and the evaluation plan.

6.26. Health screening is an integral part of disease prevention, involving the functions of different disciplines of the health services, each being responsible for screening measures for different diseases and different target groups. Up till now, there has been little collaboration between the public and private sectors on this matter. We recommend the formation of an advisory committee to evaluate the overall effectiveness of the opportunistic case-finding approach and to advise on the need for more screening on the basis of the findings of the evaluation and the adoption of other approaches.

Conclusion

6.27. Health screening plays an important part in any early detection and disease control programmes.

Unlike curative services which are almost entirely patient-initiated, screening services are provided either as part of a disease prevention programme or are promoted by frontline health workers. To ensure that the investment of resources on screening services is justified, we should adopt the most cost-effective approach for different target groups.

6.28. In general, we are satisfied with the present screening services that are universally accessible to pregnant women and pre-school children and feel strongly that these should be extended to school children. These services which are developmental-related help to reduce the incidence of preventable genetic diseases and the prevalence of developmental disorders which are amenable to early intervention. Continued emphasis should be placed on these programmes and attendance of mothers and children should be further promoted.

6.29. In the case of health screening for adult groups which should be more disease-related, we have adopted a very cautious attitude. We do not consider it appropriate to introduce separate screening programmes for the general population on a massive scale. The new initiatives that we have proposed are based on the existing service infrastructure, either as part and parcel of the FHS or a component of good family practice at GOP clinics. Neither have we advocated that such screening services should be made free for all. Except for those who cannot afford to pay, we consider that these screening services should be provided at a charge to recover the investigation costs including laboratory expenses. This would help to instil among individual recipients of the service a

sense of responsibility towards maintaining and promoting their own health and provide a rational basis for regulating the demand for these quality services. Lastly, these screening services should be introduced on a pilot basis subject to close monitoring and evaluation.

CHAPTER SEVEN

STUDENT HEALTH SERVICES

Introduction

7.1. Children are our future. It is an important role of government, recognized throughout the world, to ensure that young people grow up to be healthy adults. We have evaluated the existing health services for pre-school children in Chapter Five. This chapter discusses the provision of health services for school children, with particular reference to the School Medical Service Scheme which the Working Party is specifically required to review by its terms of reference.

Current Provision of Health and Medical Services for School Children

Background

7.2. The first School Medical and Health Service which began in 1927 was provided entirely by Government staff. In the 1920s, its main functions were to detect as early as possible any health problems in school children, to cure minor complaints and correct minor defects, and to control the hygiene standards in schools. By 1955, Government was having difficulties in continuing the service owing to a shortage of medical staff and facilities to meet the growing demand. In 1959, alternative arrangements were devised resulting in the health aspect of the service being separated from the medical aspect. The health services were subsumed within the general health services provided by the then Medical and Health Department

while the medical aspect was contracted out to private practitioners who volunteered to participate in a scheme. This was the beginning of the School Medical Service which was officially established in 1964.

The School Medical Service

Objectives

7.3. The School Medical Service Scheme has been in operation since 1964 with the following objectives -

> " To enable school children to gain the maximum benefit from available education facilities, and to ensure, as far as possible, a healthy adult population in the future. "

7.4. As made clear in the short title to the School Medical Service Board Incorporation Ordinance (Chapter 1111), the scheme provides economical medical treatment for the students of participating schools. The scheme is extended to all children in Primary Schools and Secondary One to Secondary Three of Secondary Schools.

7.5. For the sake of clarity, the working group appointed by the Secretary for Health and Welfare in late 1988 to review the SMS[1] recommended that the

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[1] The working group was appointed to review the objectives and operation of the SMS in the light of some growing dissatisfaction about the scheme at the beginning of the 1988/89 school year. Its recommendations have led to certain changes in the operation of the scheme in the following year which were discussed in paragraphs 7.9 to 7.11.

objectives should be slightly rewritten as follows -

> "To promote and maintain the mental and physical health of school children primarily through low-cost medical treatment so as to enable them to obtain the maximum benefit from available education facilities and to develop into a healthy adult population in the future."

This revised version was subsequently endorsed by the SMS Board.

Operation of the Scheme

7.6. The SMS is operated on a school basis. Participation in the scheme is entirely voluntary on the part of the schools, students and doctors. Students of a participating school who wish to join the scheme are enrolled with a doctor participating in the scheme. In return for an annual capitation grant from Government and an enrolment fee payable by parents, the participating doctor is obliged to provide an unlimited number of medical consultations for the student enrolled with him during the year. In the school year 1989/90, a per visit charge was introduced. In return, the student-patient is entitled to a minimum prescription of two days' medicine.

7.7. Doctors who participate in the scheme provide mainly a curative service. He will examine the student-patient, make a diagnosis and deal with the student's problem by treating him in his clinic and supply him with medicine, or where necessary, refer him to an appropriate person or institution for further examination or treatment.

Administration

7.8. The scheme is administered by a statutory Board, the SMS Board, constituted under the provisions of the School Medical Service Incorporation Ordinance. The Board has the statutory duty to operate a scheme to provide economical medical treatment to participating school children and to administer any ancillary matter in connection with this duty. The Board has powers to manage the scheme, to enter into contracts, to acquire, transfer or dispose of land, buildings, vehicles and equipment and to raise or borrow money. It has its own office in rented accommodation and employs a full-time secretary and six staff. The cost of this Administration Unit is met from funds provided by the Department of Health under the medical subvention programme.

Recent Developments

7.9. Until 1988, the SMS Board operated a scheme which involved the school authorities selecting a doctor(s) for the school. All participating students in this school were then registered with the selected doctor. As a result of an internal review by the Board, the arrangement was replaced by one in which the parents themselves choose the doctor. While this change was generally regarded as an improvement, it generated concern on the part of the participating doctors who complained that the parental choice system had given rise to more frequent attendances which in turn threatened the viability of the scheme.

7.10. As a result, a working group was appointed by the Secretary for Health and Welfare to review the

objectives and operation of the scheme. A number of modifications were made to the scheme on the recommendation of the working group which included, inter alia, raising the level of remuneration for doctors in the scheme and introducing a per visit charge.

7.11. In the school year 1990/91, a total of 352 429 students, or 45% of the eligible student population, are enrolled with the SMS. The number of doctors participating in the scheme was 508 at the beginning of the school year. A doctor receives an annual capitation grant of $105 from Government for each child registered with his practice, a $15 enrolment fee plus a $12 charge per visit payable by the parent. A provision of $41.5 million has been included in the 1990/91 financial year for subventing the SMS[2].

Health Services

7.12. Health services for school children are provided by the Department of Health and the Education Department, the former being subsumed within the general health services and the latter through the Combined Screening Programme.

Health Services, Department of Health

7.13. Health services provided by the Department of

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[2] Enrolment figures and Government provision for previous years are at Appendices 12 and 13.

Health specially to children at school are presently confined to health education and inoculation and vaccination services. These services are operated from the department's regional health offices and in the case of health education, health talks, video presentation and distribution of pamphlets and posters are carried out with the help of the CHEU. Health inspectors from the regional health offices also inspect schools and advise on the general environmental hygiene and sanitary facilities.

7.14. As members of the public, school children who require medical consultation or treatment may also attend GOP clinics and other specialized clinics run by the Department of Health. The latter include the child assessment centres.

7.15. A comparison of the health services for school children with services for pre-school children provided under the department's FHS which are considered in Chapter Five reflects the shortcomings in the former. At MCH centres, a full range of well-integrated preventive and promotive health care services is provided to children of the 0-5 age group. During visits to clinics undertaken by the Working Party, we saw the operation of these services. We were impressed by the comprehensiveness of the programme, the continuity of care rendered and the full records being maintained. We feel that health services for school children should have been built on such existing strengths. In particular, the value of the medical record of the child built up at MCH centres should be linked to health services for school children as a means to ensure continuity of care.

Combined Screening Programme, Education Department

7.16. The CSP run by the Education Department consists of administration of screening tests in four areas -

(a) eye-sight,
(b) hearing,
(c) speech, and
(d) learning.

It aims at early identification of sensory defects in school children so that remedial measures could be taken, before these problems develop into major handicaps causing difficulties in learning.

7.17. The CSP covers about 90 000 children, representing 100% of Primary One students in ordinary primary schools and some 700 Primary Two students (also aged six years) in schools of the English Schools Foundation.

7.18. The CSP team consists of qualified teachers with training in special education. These teachers are responsible for visiting schools and administering screening tests in eye-sight and hearing. Ordinary class teachers are given checklists which help them to identify children with speech problems and learning difficulties. The role of teachers in identification is an important component in the existing mode of CSP.

7.19. Children who are identified to have problems are given follow-up assessment. The average percentage of these children over the past three years is as follows -

(a)	Eye-sight	5%[3]
(b)	Hearing	6%
(c)	Speech	6%
(d)	Learning	6%

7.20. Children who have failed the eye-sight screening test and are considered to be in need of immediate attention are referred to either ophthalmologists or optometrists for consultation. At present, the Education Department has the support of the following institutions in rendering such services to the children :

(a) Hospital Services Department : Eye Clinic in the Yau Ma Tei Jockey Club Polyclinic;

(b) Voluntary agency : General Eye and Low Vision Clinic of the Society for the Blind; and

(c) Hong Kong Polytechnic : Optometric Clinic of the Department of Diagnostic Sciences.

The fees charged at the above facilities are identical to that charged by the government out-patient clinics. Alternatively, parents may choose to seek consultation from ophthalmologists in private practice.

7.21. Children who failed the hearing screening test will be given full scale audiological assessment at the Special Education Services Centre if their

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[3] Children wearing glasses have their eyesight tested with glasses on.

parents have opted to accept the service. After assessment, those children who require treatment from specialists will be referred to HSD.

7.22. For children identified by teachers as having speech and/or learning difficulties, follow-up assessment and remedial service will be provided by specialist staff in the Special Education Section. The Special Education Section will also provide schools with brief reports and appropriate advice on children ascertained to have problems in any of the areas mentioned above.

<u>School Dental Service</u>

7.23. For the sake of completeness, this chapter also contains a brief description of the School Dental Service provided by the Department of Health. We are, however, aware that the dental service including the School Dental Service is being separately reviewed by the Dental Sub-committee of MDAC.

7.24. The School Dental Service was introduced in September 1980 to provide dental services for primary school students in purpose-built school dental clinics. The scheme is intended to prevent dental decay from firmly developing in young children by providing a basic dental service at primary school level. Participants are provided with an annual dental examination and simple conservative treatment as well as preventive services and oral health education. Like the SMS, the School Dental Service is operated on a school basis under which individual students participate voluntarily, upon paying an enrolment fee of $10.

7.25. The number of participants in the scheme has been rising steadily since its commencement in 1980. In the school year 1990/91, a total of 998 schools and 400 804 students are participating in the scheme, the participation rate is 74.4%. The approximate annual expenditure of the School Dental Service for the financial year 1989/90 was estimated to be about $35 million. The average annual cost per participant based on a costing exercise conducted in 1987 and updated in 1989 was $104.50.

An Evaluation of Current Provision of Health and Medical Services for School Children

7.26. Health services for school children are one of the areas that has attracted the greatest volume of comments from respondents who put forth written submissions and in press reports during the course of our deliberations. All these views have been given careful consideration in our evaluation of the current provision of health and medical services for school children. In addition, we have drawn upon the experience of Singapore[4]. We have also had the benefit of the findings of a survey on parents' views on the SMS conducted jointly by the Consumer Council and the SMS Board.

The School Medical Service

7.27. We maintain that Government has the responsibility to promote and maintain the health of

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[4] A brief description of the School Health Service in Singapore operated by the Ministry of Health is at Appendix 14.

school children, to ensure a healthy adult population in the future and to enable them to get the maximum benefit from available education facilities. The motto "Healthy Children are Better Learners" more than explains itself. The question is whether provision of low-cost medical treatment remains necessary or appropriate to achieve the desired objectives in the light of developments in health and medical services for children and changing social and economic conditions over the past 25 years.

7.28. The SMS has served its purposes in the early years when most parents could not easily afford private medical care for their children and there were insufficient government facilities to cater for their needs. In those days, many children relied on the SMS providing low-cost medical treatment to minimize their absence from school due to unattended illness.

7.29. As constrained by the nature and scope of the service, the contribution of SMS towards an optimal health service for school children providing whole-person care can only be marginal. It functions mainly as a form of low-cost treatment for minor ailments, which is by itself hardly adequate to promote the healthy development of children. Moreover, the health needs of children and the population as a whole have changed as the general health conditions of the population have improved over the past decades. The modern concept of health adopted in many countries in devising their health care policy is towards a more health promotion and disease prevention approach. The objective of SMS to promote and maintain the health of school children primarily through economical medical treatment is therefore considered outmoded.

7.30. Nowadays, over 70% of out-patient medical care is being taken care of in the private sector. Hong Kong has become more affluent than it was in the 1960s[5] and the majority of couples now have one or two children[6]. It is unlikely that the average family would face undue hardship if they have to pay the occasional charge of $80 for private medical consultation for their children. This partly accounts for an average enrolment rate of less than 50% in the SMS over the past five years, despite the fact that the scheme is made universally accessible to all children in schools from Primary One to Secondary Three. In a recent survey of parents' views on SMS conducted by the Consumer Council, the majority of those who did not join SMS said that they had doctors of their own. Even among those who had joined, some 20% of those who had visited a doctor since the beginning of the school year to the time of interview had consulted a doctor(s) other than the SMS doctor. It appears therefore that SMS is providing a supplementary rather than an essential service.

7.31. Furthermore, the public sector out-patient service has also developed considerably over the last

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[5] Per Capita Gross Domestic Product at constant 1980 market price was $7,952 in 1961 and $43,757 in 1989.

[6] The average household size of an unextended nuclear family (i.e. parents and unmarried children) decreased from 4.6 in 1976 to 3.8 in 1986. Source : Hong Kong 1986 Bi-Census Main Report.

25 years. The number of GOP clinics has increased from 29 in 1960 to the present 54. They are strategically located and easily accessible, providing subsidized primary medical consultation to all. In fact, the co-existence of subsidized care for all including school children at GOP clinics and low-cost treatment universally available to school children under the SMS has been criticized by some people as duplication. Moreover, there is now better provision of preventive health care services for pre-school children through 33 full-time and 12 part-time MCH centres spreading throughout the territory. The MCH programme provides a comprehensive range of counselling, screening and examination for the supervision of healthy development of pre-school children. Through regular attendances at these centres, parents are made more aware of the importance of child health. This enables the early detection of defects and problems which would otherwise have been overlooked until the child enters school.

7.32. The above factors together would diminish the need for Government to provide, on a universal basis, low-cost medical treatment to school children through the SMS. Parents already have the option of attending either government out-patient clinics or their own doctors. As stated by the Estate Doctors Association in its submission, there is little justification, in present-day circumstances, for a "low-cost" service which can lead to a "low standard" service, and the Association would prefer public money being spent on a subsidized service for the needy. The School Medical Service Doctors Association said that while doctors would be happy to provide a low-cost service to the needy and the underprivileged section of the community, the present SMS scheme is "a free lunch to a large sector of the community at the expense of the doctors".

7.33. We therefore consider the objectives of SMS to promote and maintain the health of school children primarily through low-cost medical treatment to be outmoded. The considerations which led to the introduction in 1964 of heavily subsidized medical treatment for all school children no longer apply today. The contribution of SMS to the overall health of school children is only marginal and as such, the resources now devoted to this service are not being used efficiently.

Health Services

7.34. Health services provided by the Department of Health and the Education Department for school children are insufficient and limited in scope. They have been developed on a fragmented basis without an integrated approach.

7.35. The main emphasis of the Department of Health's service is on inoculation and vaccination of primary school students. There is no physical examination of school children and personalized care is lacking. Documentation of health records virtually does not exist. This prohibits continuity of care and provision of individualized attention to the children. The service also fails to identify and respond to recent health problems in school children such as obesity and scoliosis. Due to the absence of documentation of health records, there is no data upon which to update common health problems and health needs of school children, and to introduce timely interventionary measures. The health education programme is not structured to cater for the needs of children at various stages of their development.

Secondary school students are only provided with health education delivered on an invitation basis.

7.36. The CSP provided by the Education Department to Primary One students only is also restricted in scope and coverage. It overlooks problems in children which may develop in the later stage of their development. Screening tests are done on a mass basis with no individualized attention given to the personal need of the child. Moreover, there is little integration with health and medical services of the Department of Health and HSD except the arrangements for referral.

7.37. In conclusion, we consider that a continuous, co-ordinated and cost-effective health programme for school children is lacking in Hong Kong. The present problems associated with a fragmented approach have to be addressed. Urgent attention should also be given to establishing a basis for research and data collection to help establish the health needs of our younger generation and to plan ahead. We feel strongly that there is a need to introduce an integrated Student Health Service with emphasis on health promotion, disease prevention and continuity of care.

<u>The Proposed Student Health Service</u>

7.38. It is Government's responsibility to promote and maintain the health of school children to ensure that they derive maximum benefit from the educational system and grow up as healthy adults. In the light of the evaluation in the preceding paragraphs, we <u>recommend</u> that the School Medical Service should be abolished in favour of a mainly preventive and

promotive Student Health Service to be operated by the Department of Health.

7.39. We are fully aware that to abolish the SMS may raise objections in some quarters. However, we hope that the detailed explanation of the objectives and contents of the new SHS and the availability of alternative arrangements within the public sector to take care of the genuine needs for curative service among students who cannot afford private care may allay undue apprehension over our recommendations.

7.40. The SHS should be developed from the current provision of health services for school children run by the Department of Health. It should provide an integrated and comprehensive service essential for the continuing assessment of students at various stages of their development. It should comprise specially designed preventive health programmes for primary and secondary school students to cater for their health needs. The service, to be introduced in phases, should progressively cover all primary and secondary school students, as compared with the SMS which is available to students up to Secondary Three only. There would be prescriptive developmental examination of all students in the identified age groups at specific intervals of school attendance, and follow-up health care at designated regional health centres. Health counselling and health education would be provided to students at different stages in their development process. A comprehensive vaccination programme against certain diseases would be continued.

7.41. We have considered the possibility of involving the private sector in the SHS but do not feel

it is realistic to expect private practitioners to provide preventive and promotive health services especially on a continuous and standardized basis. Comprehensive, well-designed and integrated health services should be provided by Government. Furthermore, it should be the role of Government to promote the understanding of child health and to ensure that parents and teachers are aware of the presence of disorders among school children.

7.42. While preventive and promotive health services are provided under the SHS, there would still be the need for primary medical care services to be made available to school children who cannot afford consultation with a private practitioner. Having considered the feasibility of alternative arrangements, we feel that this function should be performed by the GOP clinics of the Department of Health.

Goal and Objectives

7.43. We recommend that the new SHS should have the following goal -

> " To promote and maintain the health of school children so that they can derive maximum benefit from the education system ".

7.44. In pursuit of this goal, we recommend that the objectives of SHS should be -

(a) the promotion of desirable health knowledge and practice for motivation of self-care and individual responsibility in health;

(b) the prevention of ill health and disease through timely vaccination and early detection of health and educational problems; and

(c) the provision of facilities for the further assessment of defects or disorders and referral to early treatment and rehabilitation services.

<u>Scope of Service</u>

7.45. We <u>recommend</u> that SHS should comprise the following eight components -

(a) periodic medical examination of full-time students aiming to detect any abnormalities;

(b) identification and early detection of health problems in children requiring special education or health care;

(c) follow-up health care and continuous medical supervision at general and specialist clinics;

(d) prophylactic immunization of children against specific diseases;

(e) health counselling and health education;

(f) maintenance of a comprehensive health record system including patient-held medical records to facilitate continuity of care;

(g) supervision of the sanitary conditions and environmental hygiene of schools, and control of communicable diseases; and

(h) co-operation with parents, schools and the Education Department to ensure the happy, healthy development of children in school.

Operation

School-based Health Programmes

7.46. We have drawn up a school-based health programme for primary school students and another one for secondary school students taking into consideration the local health needs, availability of resources and the current provision of health services for pre-school children and school children[7]. In so doing, reference has been made to the school health programmes of other countries, and particularly that of Singapore in view of its cultural, geographical and epidemiological similarities with Hong Kong. These health programmes should be reviewed regularly to cope with the changing health needs of school children.

7.47. Visiting health teams would go to schools annually to conduct immunization, screening, medical examination and health education activities according to the proposed programmes. Medical examination would be conducted for every child at Primary One, Primary Six and Secondary Three. Children at other levels

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[7] Details of these programmes are at Appendix 15.

would have their health status updated and would go through other screening tests performed by nurses during the annual visit. School children with problems detected or requiring further assessment will be referred to the regional health centres for school children. It is envisaged that a standard visiting team should consist of two medical officers, a nursing officer, a registered nurse, an enrolled nurse and a clerical assistant.

7.48. One important feature of SHS is the maintenance of comprehensive and complete medical records for individual students, as a continuation of the child's MCH records. These records would be updated by the health team during annual visits to schools. Detailed record keeping would benefit the student and the service. It enables the health team to keep track of the development of the student. The abundant health data generated by the SHS would facilitate the Department of Health to identify changing health problems of school children.

7.49. As a means to facilitate communication with parents and to educate patients on the health status of their child, the medical record system mentioned above would be supplemented by personal health booklets to be held by the students themselves. Observations on the student by the visiting health team would be recorded in the student's health booklet. As proposed in paragraph 5.29(b), these personal health booklets should also contain the child's MCH records to provide a complete history of the child from birth. In circumstances where the child's conditions require further assessment, the parents would be advised to take the child to seek further assessment either from

the SHS's regional health centre or from private practitioners.

Regional Health Centres

7.50. Two designated health centres would be set up, one for the Hong Kong and Kowloon regions and the other for the New Territories. These centres would provide general and specialist clinic consultations for students referred from visiting health teams, GOP clinics and private practitioners for follow-up assessment, advice and referral for remedial treatment. As the SHS Headquarters, it would be the home base for school visiting health teams, providing facilities for laboratory tests, audiometry, refraction and dispensary services by staff of the Department of Health.

7.51. Besides general paediatric service, the regional centres should also provide specialist clinic sessions for a range of major health problems of school children so that further assessment could be made. The general paediatric clinics would be manned by medical staff of the Department of Health with special training in paediatrics while the specialist clinic sessions should preferably be staffed by specialists from the universities, hospitals and private medical sector on a part-time sessional basis. This arrangement is considered more cost-effective as there would not be sufficient workload to justify the engagement of full-time specialists by the Department of Health.

Research, Evaluation and Staff Training

7.52. Research and evaluation would be carried out in collaboration with the universities, the medical

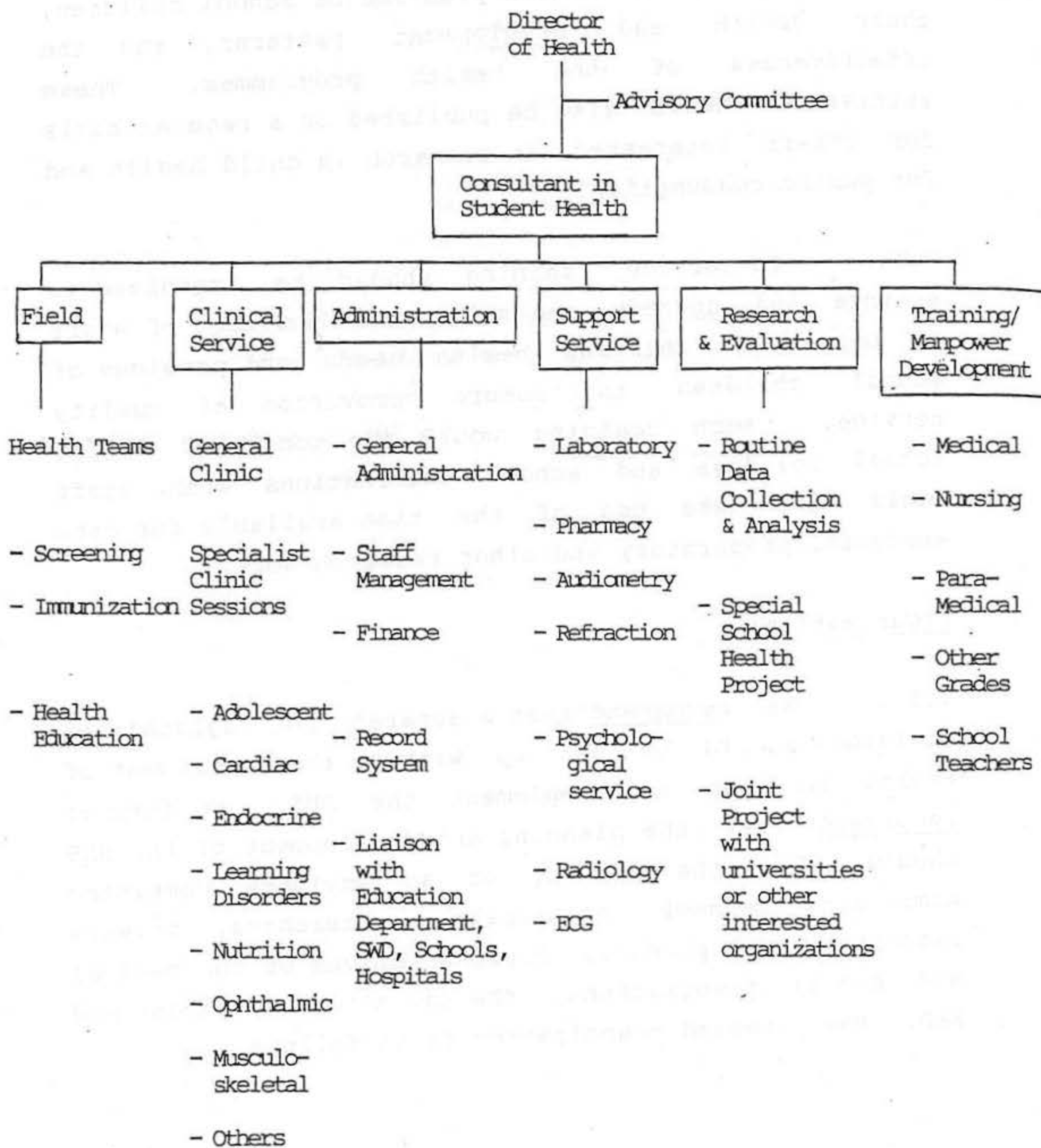
associations and the private medical sector. Data collected and survey findings would be useful to determine and evaluate methods for the management and control of common health problems of school children, their growth and development patterns, and the effectiveness of the health programmes. These statistics should also be published on a regular basis for others interested in research in child health and for public consumption.

7.53. In-service training should be organized to enhance and upgrade the skills and knowledge of staff to cope with changing health needs and problems of school children to ensure provision of quality service. Such training would be conducted during school holidays and school examinations when staff would also make use of the time available for data analysis, preparatory and other research work.

Organization

7.54. We recommend that a separate non-regionalized division should be set up within the Department of Health to plan and implement the SHS. We further recommend that the planning and development of the SHS should have the benefit of an advisory committee comprising school principals or teachers, private practitioners, parents, representatives of the medical and dental associations, the Education Department and SWD. The proposed organization is as follows -

Proposed Organization of the Student Health Service



Provision of Curative Service

7.55. The existing SMS is providing school children access to a form of curative care which is inexpensive and convenient. Although our review of the demographic and socio-economic changes over the past 25 years has led us to believe that the majority of students would not have undue hardship in seeking primary medical care even if the SMS did not exist, there remains a certain proportion of the student population who may require subsidized care. The continued provision of some form of subsidized curative service was an issue that has been debated extensively during the Working Party's deliberations.

7.56. While we are conscious of the likely resistance to replacing the SMS with the SHS, we wish to emphasize that we are not suggesting that Government should withdraw or retreat from its commitment and obligation to promote the health of our younger generation. On the contrary, we are urging for early improvements to the delivery of health care to school children. In terms of financial commitment, the new SHS would cost Government about $70 million a year on full implementation. The existing SMS requires some $40 million to provide.

7.57. One of our terms of reference requires us to assess the resource implications of our recommendations. We are therefore obliged to ensure that Government resources which afterall are taxpayers' money are used efficiently. Given limited Government resources, we consider that priority should be given to provision of the most cost-effective service which would benefit the greatest number of people. As a

matter of principle, Government should not be expected to shoulder the funding responsibilities for all preventive, promotive and curative services especially taking into account the economic realities of our low tax system and the general affordability of the population. Parents have a definite role to play in looking after the health of their children and a duty to perform when their children are sick.

7.58. On the other hand, the present financing of SMS is fraught with problems : participating doctors complain that Government is trying to provide a free lunch for all at their expense and participating parents complain that their children are being treated as second-class patients. It may not be realistic to expect the scheme to continue on its current basis if the objective of quality service is to be achieved.

7.59. We have considered whether a more viable alternative, say, in the form of an insurance scheme for students with contribution from Government and parents, might overcome the present shortcomings of SMS and provide continued access for all to subsidized care. However, our preliminary investigation has indicated that this would involve costs many times greater than the present expenditure which could not be easily justified. An annual premium of $1,000 for primary care insurance was quoted by insurance firms approached by the SMS Board. Another proposal estimated that with Government contribution and payment of an enrolment fee and per visit charge by participants at current levels, parents would have to contribute an additional $350. It is most unlikely that the majority of parents would be prepared to contribute to such a scheme.

7.60. A further alternative is to confine the subsidy to needy students. This would require means-testing students to determine their eligibility for subsidy. While we are aware that various forms of means-testing arrangements are currently in place to determine eligibility for certain allowances for students, we do not consider that a simple formula could be devised to determine one's need for subsidy in medical care which may depend on the student's health condition. For example, an average-income family which would have little difficulty in paying for infrequent visits to a private doctor might experience hardship if the child was chronically sick and required frequent consultations. Furthermore, in a situation where school children as members of the public already have access to subsidized medical care at GOP clinics which act as a safety net, we do not consider it desirable or cost-effective to introduce another form of subsidized care, especially one which could be administratively cumbersome and requires close monitoring to prevent abuses.

7.61. We have therefore concluded that the expected small group of students who cannot afford to go to private doctors after the abolition of SMS should obtain subsidized curative care from GOP clinics. Our decision must be seen in the context that a new SHS providing preventive and promotive services will be available to all students and in turn reduce the incidence of sickness. Also, under present circumstances, it is not possible to find an acceptable alternative to SMS which could meet the criteria of efficient and cost-effective use of Government resources, a fair sharing of responsibility between Government and parents and provision of quality care to students.

7.62. While we expect only a small proportion of the students currently participating in the SMS to seek curative treatment from the GOP clinics following the abolition of SMS, it is difficult at this stage to ascertain the likely increase in demand generated by students. Our other recommendations in respect of the GOP service would also affect the total patient load and the management of clinic resources. We therefore recommend that the Department of Health should monitor the utilization of clinic service by students and make appropriate adjustments in the light of the demand for service in each district.

7.63. The reserve capacity of the GOP service in terms of physical facilities would make it easier for some quick adjustments to be introduced, provided that additional resources are available. By this, we are referring to the fact that in the 54 GOP clinics over the territory, only 143 out of a total of 182 consultation rooms available were in use in 1989. Moreover, there are clinics under planning, with seven new clinics to be completed by 1992 and six more in 1996. Depending on the staffing situation, additional clinic sessions could be operated by Government medical officers or private doctors on a part-time honorarium basis. Other adjustments could include designating consultation rooms for students at some of the larger and busier clinics, allocating special priority discs to them, introducing an appointment system or operating extra doctor sessions.

Phased Implementation

7.64. Allowing time for planning and assuming that resources are forthcoming, we recommend that the school-based programmes of SHS should be introduced in

stages, commencing in the school year 1992/93. The first stage would take place at the start of the academic year 1992/93 when the first phase of the school-based programme would be launched and the first regional health centre commissioned. At the same time, the SMS would be discontinued. To meet this schedule, the first regional health centre should preferably be developed from vacated school premises in the urban area or space made available in the Department of Health's existing or planned facilities.

7.65. We propose that the tentative schedule for implementation should be -

Phase	Timing		Services Provided	Venue
I	1992-1993	a)	School-based programme for Primary 1	School-visiting health teams
		b)	Specialist and other support services	Regional health centres
		c)	Existing health services for Primary 2 to Primary 6 continued	School-visiting health teams
II	1994-1995	a)	School-based programme for Primary 2 to Primary 6	School-visiting health teams
		b)	Specialist and other support services	Regional health centres
III	1996-1997	a)	School-based programme for Secondary school students	School visiting health teams
		b)	Specialist and other support service	Regional health centres

7.66. The CSP run by the Education Department should form part of SHS. This integration would provide professional support for CSP and facilitate the continued assessment and monitoring of the development of the child throughout the various stages. In this connection, we strongly recommend that the Department of Health and the Education Department should jointly consider the matter with a view to achieve integration of CSP with the SHS and to decide on the best timing of such integration.

Conclusion

7.67. We are convinced that SHS, essential to the growth of school children into a healthy adult population, is an improvement over existing arrangements. The desirable features are highlighted below -

(a) total coverage of children in primary and secondary schools in preventive and promotive health services;

(b) periodic medical examinations at regular intervals to detect abnormalities;

(c) a comprehensive programme of health screening for early detection of educational and health problems;

(d) maintenance of health records for continuity of care; and

(e) closer contacts with parents and schools to foster healthy development of school children.

CHAPTER EIGHT

DELIVERY OF PRIMARY MEDICAL CARE IN CLINIC SERVICES

Introduction

8.1. Primary medical care is the frontline medical care and that part of the curative service where the patient usually makes his first contact with the doctor and has direct access to him. In the public sector, primary medical care is primarily delivered through a network of GOP clinics. In the private sector, primary medical consultations are provided by private practitioners, whether in group or solo practice. We consider that the development of quality primary medical care has been seriously neglected in the public sector and to a varying extent in the private sector. However, it is this service which, if properly developed, has the greatest potential towards promoting the general health of the population and building a cost-effective health care system. It also contributes significantly to the policy objective of ensuring the delivery of continuing, comprehensive and whole-person medical care to individuals in their home or natural environment[1].

8.2. In this chapter, we review critically the existing GOP service and put forward our recommendations for improving the delivery of primary medical care in both the public and private sectors. As required

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[1] See paragraph 4.7.

specifically by our terms of reference, we have also considered issues of improved co-ordination between out-patient clinics and hospital services and closer collaboration between the public and private sectors.

The Existing System of Primary Medical Care

8.3. Primary medical care refers to the point of first contact between the patient and the curative medical services. Primary medical care is not the equivalent of primary health care : the latter includes a much wider spectrum of activities aiming at health promotion, disease prevention, health maintenance and rehabilitation, which are being dealt with in other chapters. However, in order to provide continuing and comprehensive care to the individual, primary medical care should encompass services which are preventive, promotive or rehabilitative in nature in addition to the curative element.

8.4. In our discussion on primary medical care, we have excluded accident and emergency services in hospitals which are not directly under the Working Party's ambit of review although very often, they are also the patient's first contact with the health system.

8.5. In many industrialized countries of the world, primary medical care has been available through general practitioners, clinics and polyclinics and other similar institutes for a long time. They have been an early and integral part in the historical development of a country's health system but their prominence and the important role they play have been overshadowed over the past few decades by the development of highly-specialized, hospital-based services.

8.6. In Hong Kong, the system of primary medical care is a dual system with services provided in the public and private sectors. In the public sector, these are provided in GOP clinics and to a limited extent, in out-patient departments of subvented hospitals. In the private sector, the service is provided by over 2,000 private practitioners. According to the General Household Survey[2], approximately 70% of out-patient medical consultations were with private practitioners, 15% with doctors in the GOP clinics, and the remainder were accounted for by consultations with other types of western doctors[3] and traditional Chinese practitioners. The same pattern of utilization of health services was also borne out by the findings of the HKU General Population Survey[4]. Among the respondents in this survey who had a health problem and had sought professional advice in the two weeks preceding the telephone interview, 65% sought care from the private sector while 15% were seen at GOP clinics.

Public Sector Primary Health Care :
The General Out-patient Service

8.7. As at end 1989 the Department of Health operated 54 GOP clinics spreading throughout the territory providing service to members of the public.

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[2] 1989 First Quarter General Household Survey conducted by the Census and Statistics Department.

[3] Company doctors and out-patient departments of subvented and private hospitals.

[4] See paragraph 2.5 and Appendix 3.

These clinics are sometimes stand-alone clinics but are often housed within polyclinics providing other medical facilities. The general opening hours of these clinics are in two sessions : from 9:00 a.m. to 1:00 p.m. and 2:00 p.m. to 5:00 p.m. on weekdays and morning sessions only on Saturdays. Some of these clinics in the more populated areas also provide evening[5] and Sunday and Public Holiday[6] services. In addition, clinic services to remote areas and outlying islands are provided through travelling dispensaries, floating clinics and a helicopter medical service. In 1989, a total of 80 170.5 doctor sessions were provided, with a total attendance of 4 903 412 of which slightly over four million attendances were cases seen by doctors while the rest were made up of injections, dressings and casualty cases.

8.8. The 54 clinics together provided a total of 182 consultation rooms but only 143 of them were in use in 1989. This discrepancy can be partly explained by the fact that the standard design of the new generation of GOP clinics consists of six consultation rooms, making allowance for future expansion. In practice, not all the consultation rooms are fully utilized especially at the early stage of operation taking into account population build-up in the area and availability of resources.

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[5] Evening clinic service operating from 6 to 10 p.m. is available in 19 clinics.

[6] Sunday and Public Holiday service operating from 9 a.m. to 1 p.m. is available in eight clinics.

8.9. For operational and planning purposes, a figure of 120 cases seen per doctor per day is applied[7]. In theory, this would mean that some 60 patients are seen per doctor session at an average consultation time of 3.3 minutes. However, the Department of Health's clinic statistics for the year 1989 showed that the overall average number of cases seen per doctor session was 50. This figure had taken into account the workload in evening clinic sessions which usually had a higher attendance record. Also, the number of patients seen per session varied from one clinic to another[8].

8.10. Despite an average number of cases seen per doctor session of below the planned 60, there was still a significant number of turnaways. The recorded turnaways for the year 1989 were 144 815 or 3.6% of the total cases seen. These turnaways were not recorded only at the few busiest clinics[9]. In addition, individual doctors were found to have completed seeing

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[7] This is made up of 70 for the morning session and 50 for the afternoon session.

[8] The highest number of cases seen per doctor session recorded in 1989 (excluding evening, Sunday and Public Holiday clinics) was 60.2 at the Tang Shiu Kin Hospital out-patient department while the lowest was 11.8 in the North Lamma Clinic.

[9] For example, at the Yau Ma Tei Jockey Club Clinic where the average number of cases seen was 46.2, there was a turnaway of 8 950 cases; at the Sha Tin Clinic with an average of 50.1 cases seen, 10 600 cases were turned away in 1989.

all the patients within the quota well before the official closing time of the clinic session. It was also observed in the HKU GOP Survey that many clinics processed the large number of patients well ahead of closing time; in some cases all the patients were seen by doctors up to one and a half hours before the end of the session.

8.11. A $18 per consultation fee, inclusive of drugs and investigations, is charged for all patients except civil servants and their dependants who obtained the service free and the indigents for whom fees are waived by medical social workers or designated medical officers at the clinic having regard to their financial situation. The proportion of cases with their fees waived is less than 1%.

8.12. In terms of manpower, the GOP clinics are staffed by a total of 157 doctors, 331 nurses and other supporting staff. For the financial year 1990/91, the control and maintenance of surveillance over communicable diseases and provision of treatment through out-patient clinics is estimated to cost some $552 million which is equivalent to 52% of the Department of Health's budget or 8% of the total budget for hospital and health services.

Private Sector Primary Medical Care : Private Practices

8.13. Being responsible for 70% of all medical consultations, private practitioners play a very important role in providing primary medical care to the community. In Hong Kong, primary medical care is provided by both general practitioners and specialists, particularly those in general medicine or paediatrics.

Over half of all registered doctors are in private practice.

8.14. As observed by the two WHO consultants, private practice in Hong Kong is independent, competitive and entrepreneurial. The quality of service is variable : ranging from very good to less than satisfactory. Charges also differ depending on the locality of the clinic and the experience and status of the doctor. Payment for private care comes from a variety of sources. These include fees from patients, contractual arrangements with large companies on a pre-paid or fee-for-service basis or private health insurance.

8.15. Some 95% of private practitioners are in solo practice. The remaining 5% work in groups of up to 60 partners or associates who may include both specialists and general practitioners. Most of the general practitioners have little or no formal training in general practice before taking up their own independent private practice. The HKCGP has since its establishment 15 years ago organized training programmes to upgrade the skills and knowledge of general practitioners in primary medical care and to promote continuing medical education. However, the number of private doctors who have gone through such training remains very small.

8.16. We should also mention two arrangements involving private practitioners in the provision of primary medical care. One is the SMS Scheme which has been in existence since 1964 under which private practitioners are contracted by the SMS Board to provide economical medical treatment to children from Primary

One to Secondary Three. In the school year 1990/91, some 500 doctors are participating in this scheme. This scheme has been discussed extensively in Chapter Seven.

8.17. The other arrangement involves the Housing Authority and the Estate Doctors Association under which EDA is allocated a number of shop units in a new housing estate, at a full commercial rent, and its interested members take part in a ballot to determine who will run the clinics. The Housing Authority's conditions for operation include some minimum operating hours and the condition that the doctors may not operate more than one clinic outside the estate. On the other hand, the EDA encourages its members to keep fees low. As at end 1989, there were a total of 294 EDA clinics in various public housing estates.

8.18. In both schemes, doctors participate on a voluntary basis.

Current Problems in the Delivery of Primary Medical Care

8.19. Whether in the public or private sector, primary medical care mainly provides consultation and treatment of minor ailments on an episodic basis. In most cases, little attention has been given to the development of doctor-patient relationship, continuity of care and education and counselling to help patients to manage their health problems. The outcome of a medical consultation is usually characterized by a **low** level of investigation, a **high** level of medication and **little** acquisition of medical knowledge by the patients. As a result, "doctor shopping" is

prevalent[10]. This behaviour is not conducive to good medical care in which the primary care doctor should maintain a continuing relationship with the patient and be familiar with the patient's medical history. In that case his professional advice will be sought by the patient as regards referral for specialized care.

8.20. The deficiencies in our present delivery of primary medical care are discussed in greater detail in the following paragraphs. These are caused not simply by service providers neglecting the essence of primary medical care but are also the results of inadequate public education on the importance of continuity of care, the shortage of training opportunities for doctors in primary care and a medical and health programme which has been largely hospital-oriented.

Problems in the Government General Out-Patient Service

8.21. One of the main stated objectives of the GOP service is to control and maintain surveillance over communicable diseases. We consider this objective to be outmoded. Our GOP clinics are no longer centres for surveillance screening or prompt control of communicable diseases and epidemics. In practice, they are providing an accessible, basic medical care service for treating

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[10] Doctor shopping refers to the behaviour of consulting two or more doctors during the same illness, or consulting a different doctor for consecutive illnesses. This phenomenon is reported to be widespread in Hong Kong and is confirmed by the HKU General Population Survey with 46% of those interviewed reported adopting this practice.

minor, uncomplicated ailments on an episodic basis to a significant proportion of our population. The profile of GOP users has also changed [11]. If the GOP clinics were said to discharge Government's role in providing medical care facilities to that sector of the community which relies on subsidized medical care[12], the current GOP system providing subsidized care to all people across the board suffers from having no means to tell whether the users are really those in need. In brief, the objectives of the GOP service are not clear.

8.22. An attendance at a GOP clinic has been described as a patient-initiated episodic attendance during which the patient described the symptoms of his illness to the doctor who then prescribes the necessary treatment. Apart from putting down the patient's name, age and the doctor's diagnosis in a clinic log book, there is no individual record of the patient's health status. When the same patient next turns up at the clinic, there is no record of his previous attendances. The absence of individual medical records for patients is a barrier to continuity of care and has prevented the development of more efficient and effective patient

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[11] According to the HKU GOP survey, 96% of GOP patients were former attendees and some 30% of the consultations involved patients suffering from diabetes (7.2%) or hypertension (24%). Over 20% of GOP users were young children who are less vulnerable to communicable diseases under the existing comprehensive immunization programme. Over 21% were elderly patients.

[12] This is one of the stated Government policy objectives in the 1974 White Paper.

management. This has often given rise to unnecessarily frequent attendances.

8.23. The absence of medical records has hampered not only better patient care but also effective health care planning. A lack of information about the health status and disease pattern of GOP users means that there is no basis for developing the service to respond to major demographic and epidemiological changes. As a result, the GOP service has failed to develop and has remained much the same as it was decades ago. An information vacuum is partly responsible for the inertia.

8.24. Despite the variation in workloads from one clinic to another, a GOP doctor sees on average 100 to 120 patients per day with an average of 3.3 minutes per consultation. This heavy patient load provides doctors with insufficient time to understand their patients' medical history and health conditions, and virtually no time to provide health counselling or advice. Under these circumstances, there is a general tendency for doctors to satisfy their patients by prescribing a high level of medication[13].

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[13] According to the HKU GOP Survey, the outcomes of a clinic attendance were characterized by low levels of investigation and high levels of treatment. 70% of patients left the clinic without apparently any knowledge of the presumptive diagnosis. However only 2.5% of patients left without some form of medication and the most common prescription was for three kinds of medicine. This practice of prescription is in turn related to patients' expectations. About 80% of the surveyed GOP patients said that they expected some form of medication.

8.25. GOP service is relatively unpopular among our young medical graduates : over half of the doctors in GOP service are over 45 years of age and about one-third are Licentiate doctors. In the view of the WHO consultants, problems faced by doctors in the GOP service include: poor image and status, poor career prospects, lack of orientation and in-service training, lack of professional satisfaction and low morale. There is little training for doctors before and during their service although the average duration of doctors working in GOP service is pretty long. However, virtually all serving doctors said that they would welcome training, either in the form of refresher course or structured programme leading to a higher qualification[14]. Partly because of unclear objectives, lack of training and career prospects and low self-image, most doctors in GOP service appear to be resigned to the present deficiencies and are thus not motivated to improve the quality of service they are providing. For instance, we are surprised to learn that about half of the doctors responding to the survey said that the existing medical record system was satisfactory.

8.26. Other than doctors, nurses working in GOP clinics are also having problems. In our visits to the

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[14] According to the Department of Health's survey on doctors working in GOP clinics, about 48% of the 128 respondents have worked in GOP service for six years or more. 99% of the respondents welcomed training, with 79.5% of them preferred refresher courses and 65.4% in favour of full vocational training leading to a higher qualification.

clinics, we shared the observation of the WHO consultants and others that the skills and tasks of the nurses do not match. The contents and diversity of the nurses' work in GOP clinics have remained unchanged over the years despite the changing profile and expectations of GOP users. In our view, many of the tasks now performed by nurses in GOP clinics can be more appropriately carried out by ancillary staff as in the case of ward stewards in hospitals. Unlike their counterparts in the MCH centres, nurses in the GOP clinics do not seem to find theirs a professionally rewarding job[15]. The uneconomical utilization of nursing expertise adversely affects service improvement and is a great pity at a time when Hong Kong is facing an acute shortage of nursing staff.

8.27. In addition, there is no team approach in GOP clinics. A multi-disciplinary approach involving paramedics and other health care personnel has not been developed and there is very little linkage with specialist clinics or hospital-based services even though some of these are housed within the same polyclinic. Co-ordination with other sectors involved in providing community services such as welfare agencies is totally lacking.

8.28. In summary, our observations of the operation

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[15] In reality, many nurses are attracted to the GOP service because of the regular hours, no shift duties and less demanding job as compared with working in hospital wards.

of the clinics and the various surveys and reports have highlighted the following deficiencies in the GOP service -

(a) no clear objectives;

(b) little continuity of care;

(c) very basic and mostly episodic treatment of minor ailments;

(d) inadequate investigation;

(e) inadequate patient education and health counselling;

(f) heavy patient load and very short consultation time;

(g) lack of health information;

(h) low morale among doctors;

(i) inappropriate utilization of nursing resources;

(j) absence of a team approach;

(k) inadequate co-ordination with specialist clinics and hospitals; and

(l) little intersectoral communication and community participation.

At an estimated full cost to Government of $96 per attendance at 1990/91 prices[16], it is doubtful whether resources have been used efficiently.

Problems in Private Practices

8.29. One of the major problems in the private sector primary medical care is the considerable variation in the quality of service and standards of care. Besides, there is a shortage of qualified and well trained primary care doctors or family physicians. Unless standards of practice in the private sector are improved, it would not be wise to consider transferring the 15% public sector provision to the private sector. On the other hand, in order to bring about overall improvement in primary medical care to the entire community, it is incumbent upon us to include private practice in our discussions and proposals.

8.30. Many of the identified shortcomings in the GOP service are also prevalent in private practices although

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[16] The figure of $96 was estimated from the total expenditure of five GOP clinics and their total number of attendances. Calculation of this cost has included remuneration for staff working in the clinic and others outside the clinic providing supporting services, administrative overheads, drugs, depreciation of building and equipment and other recurrent expenses. It is the overall average cost of providing consultations to all types of patients (those suffering from simple episodic illnesses requiring a few days' medicine and chronic patients who are given medication for a longer period), inclusive of all services provided, for example radiological and pathological investigations.

not in all of them. These include lack of personal continuity of care, little promotive or preventive health care activity, unsatisfactory record-keeping for clinical purposes, little co-operation with other members of a primary care team, medicine dispensed in unlabelled containers and inadequate disclosure of medical information to patients. Consultation in the private sector is also generally characterized by a very high number of repeat visits and a limited supply of drugs.

Conclusion

8.31. In brief, quality primary medical care is grossly underdeveloped in both public and private sectors. Patients are provided mainly with curative care for minor medical problems. Primary care doctors in both sectors are neither performing the function of a family physician providing continuing, comprehensive and whole-person care to the individual patient nor that of a first point medical contact leading to specialized services in hospitals. Unless there is commitment, both in terms of policy and resources, to the development of primary medical care and the training of primary health care doctors, the pressure on the hospital sector would continue to increase and a cost-effective health care system would not evolve in Hong Kong. The second part of this chapter describes the improvements recommended for GOP clinics and private practices. The subject of training of primary health care doctors is dealt with in Chapter Ten.

Improvements to Public Sector Primary Medical Care

8.32. To improve the delivery of primary medical

care in the public sector, we suggest a revamping of the GOP service in terms of its objectives, scope of service, operation and management.

Objectives

8.33. While GOP clinics could continue to play its role in the surveillance of communicable diseases, we recommend that the objectives of the Government primary medical care service should be -

> "To provide quality primary medical care which is readily accessible and affordable, with special attention and provision for certain target groups, and which will act as a benchmark for the delivery of service in Hong Kong."

8.34. The above objectives are a summary of our views on the following aspects -

(a) **Quality primary medical care:** Government primary medical care service should provide a family medicine service[17] to its clients. Although reference is made to **medical** care in this context, GOP service should provide preventive as well as curative care.

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[17] Family Medicine is the medical discipline which provides primary (first contact), continuous (on going responsibility), comprehensive (illness of all kinds) and whole-person (physical, psychological and social) care to individuals and families in their natural (home and working) environment.

Establishment of a continuing relationship between the doctor and the patient through good and comprehensive medical records, longer time for consultation, dissemination of information to patient and provision of health education should be a top priority. In the long run, this practice would pay dividends as more rational treatment programmes with a view to reducing the frequency of attendances could be devised, particularly for patients with chronic diseases. With a better understanding of their own medical conditions, improved patient compliance with treatment and greater self-reliance could also be attained.

(b) **Accessible:** GOP clinics should be conveniently located to ensure geographical accessibility and in the case of remote areas, Government should continue to assume the responsibility of making available such medical facilities.

(c) **Affordable:** to ensure equity, we consider that the public sector primary medical care services should be made readily affordable. However, this should not be taken to mean that services at Government clinics should be provided at substantially subsidized rates for all. To optimize the use of resources, a realistic system of charging with special provision for the needy groups should be developed. In the long term, we feel that charges in GOP clinics should not fall too far behind the cost to the public purse of the service. However, certain groups of people

may have difficulties in affording such charges and for this reason, we consider that target groups who could obtain the service free or at reduced rates should be defined. This will be elaborated further in Chapter Thirteen on Funding and Implementation.

(d) **Benchmark for the delivery of service in Hong Kong:** one way in which Government can influence the quality of service in the private sector is through the setting of example. This we consider preferable to regulation. We expect that improvements in GOP clinics would encourage general practitioners in private practice, particularly those in the same locality to improve the quality of their service in order to retain their patients and attract new ones. The adoption of good standards is of course a matter for individual practitioners but interaction and collaboration between the two sectors with a view to improving quality of service should remain one of our main objectives in developing the Government primary medical care service.

Basic Features

8.35. To meet the above objectives, we consider that the GOP service should be developed on the concept of good family practice which should possess the following features -

(a) provision of preventive, promotive, curative and rehabilitative care;

(b) facilities and practices conducive to continuity of care;

(c) easy referral to secondary care and to services outside the health sector;

(d) efficient use of professional manpower resources;

(e) adoption of a team approach;

(f) elements conducive to maintaining staff interest and morale; and

(g) community involvement, say, in terms of promotion of self-reliance.

8.36. In addition, the GOP service should be developed to provide training opportunities for GOP doctors to equip them better to discharge the role and functions expected of them in the revamped service and to enable them to pursue a career in family medicine.

Recommended Improvements at the Service Level

(a) Training of Doctors

8.37. Training of doctors in family medicine is a prerequisite for the development of quality care in the GOP service. We recommend that provision of training for GOP doctors, whether in the form of vocational training leading to a further qualification or continuing medical education to update their skills and knowledge, should be accepted as an essential priority in the development of the GOP service. A more

comprehensive discussion on training of doctors is in Chapter Ten.

(b) Training of Nursing Staff

8.38. As stated in paragraph 8.26, nursing resources in the GOP clinics are not most effectively utilized and nurses do not find GOP work a professionally rewarding job. With the impending change of emphasis in the GOP service which will require nurses to play a greater role, we recommend that nurses in GOP service should receive special training to equip them for these responsibilities including the role of a health practice nurse[18]. The use of clinic assistants to carry out certain designated duties in order to achieve a better match of skills to tasks should also be considered. Further discussion in this area is included in Chapter Ten.

(c) Development of a Career Structure for GOP Doctors

8.39. In order to recruit and retain doctors in the GOP service and to provide them with incentives for training in family medicine, we recommend that the present career prospects for GOP doctors should be

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[18] Health practice nurse, nurse practitioner or nurse specialist are designations for specially trained nurses who are able to meet the needs of many patients who do not really need the professional attention of a doctor. These include patients who do not have a serious medical problem or others requiring routine continuing care. The concept of nurse practitioner has proven to be of great value to the delivery of health care and has gained wide acceptance in some developed countries.

improved[19]. We have noted that following the establishment of the Department of Health in April 1989, re-organization has taken place which resulted in the creation of 24 SM&HO posts for GOP clinics. Under this arrangement, small clinics in the same district are grouped together to form one unit, which will be under the charge of a SM&HO. This arrangement has provided better management, supervision and professional support to the junior doctors. However, to ensure that there are adequate incentives for training, the career structure for GOP doctors needs to be further developed to provide advancement beyond the SM&HO level.

8.40. We consider that the ultimate objective should be to develop the GOP service as a specialty and consultant posts in family medicine should be created for doctors who have acquired the necessary postgraduate qualification and experience. In addition to being deployed as clinic managers and supervisors of doctors under training in the clinics, these consultants should also be involved in liaising with specialist clinics and hospitals as well as other sectors.

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[19] At present, all doctors are eligible to be recruited into the GOP service as Medical & Health Officers. No specialist qualifications are required. Upon completion of five years' service, they can be considered for promotion to Senior Medical & Health Officers, based on their work performance. For the majority of GOP doctors, there is no further advancement beyond the rank of SM&HO. A selected few may be promoted to Principal Medical & Health Officers, working in health administration in the headquarters, usually after having undergone overseas training in public health.

Recommended Improvements at the Clinic Level

(a) Development of Medical Records

8.41. Detailed clinical information of patients is an essential tool for follow-up treatment and continuity of care. During our visits to the General Practice Unit of the HKU Department of Medicine in the Violet Peel Polyclinic and the Family Medicine Unit of the CUHK Department of Community and Family Medicine at the Lek Yuen Health Centre, we observed the operation of a manual and computerized medical record system. We were impressed by the contribution of the record system to patient care and its value for epidemiological and health services research. We welcome the pilot scheme of manual medical records for individual patients introduced by the Department of Health since April 1989 in four GOP clinics[20] which has been well received by the staff and patients. We strongly recommend that this system of medical records should be extended to other GOP clinics as soon as possible. The ultimate objective should be to computerize the clinical information system and link up the records with other units in the same clinic as well as with other clinics[21].

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[20] Medical records have been introduced at the GOP clinics in the Anne Black Health Centre, Cheung Sha Wan Jockey Club Clinic, North Kwai Chung Clinic and Tai Po Wong Siu Ching Clinic.

[21] The development of a clinical information system is discussed in Chapter Five, paragraphs 5.58-5.60.

(b) Improved Preventive Care and Enhanced Health Promotion

8.42. Effective preventive care and health promotion activities contribute substantially to maintenance of health. These include screening for diseases, health education and counselling. Increasing the patient's knowledge about his own conditions can promote self-care, enhance the value of medical contacts and reduce unnecessary consultations. At present, little of these activities take place in the GOP clinics. As a first step towards improving preventive care, we recommend the introduction of opportunistic screening for certain common diseases among the high-risk groups attending GOP clinics[22]. We further recommend that general health counselling about diet, weight and cholesterol should be provided by nurses in the GOP clinics while doctors should provide more specific counselling in relation to the patient's health problem in the course of the consultation. For example, patients with lung diseases should be advised to quit smoking while patients with diabetes should be counselled about their eating habits.

(c) Labelling of Dispensed Medicines

8.43. Labelling of dispensed medicines is another means to improve the patient's knowledge of his own health problems and to prevent the misuse of drugs. In

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[22] The screening activities proposed are discussed in Chapter Six on Screening Services.

view of the obvious benefits, we recommend that the practice of labelling dispensed medicines should be introduced in GOP clinics. Consideration should also be given to computerizing the procedure as in the case of government clinics in Singapore and that adopted in the regional hospitals in Hong Kong.

(d) Reduced Patient Load

8.44. Most of the improvements to service in GOP clinics that we have recommended so far require doctors and nurses spending more time with each patient. The present 3.3 minutes per consultation is totally unacceptable for this purpose. High levels of attendances also explain why the desirable changes have not taken place in the GOP clinics. Unless the issues of a heavy medical workload generated by an insatiable demand under the present system providing a universally accessible service at a low fee are properly addressed, the GOP clinics would not be able to break through the existing demand-imposed constraints to undergo major changes.

8.45. From our observation and the various surveys, we consider that opportunities for reducing medical workloads without adversely affecting the quantity and quality of care rendered are available. These include changes to the management of patients involving the appropriate utilization of specially trained nurses, introduction of recall appointments for patients suffering from chronic diseases who are frequent users of GOP clinics and adjustments to the operational procedures, and changes in doctors' attitude notably to address the phenomenon of clinic doctors completing

their workloads well before the closing time. We recommend that the Department of Health should give urgent attention to the various clinic management issues affecting workloads with a view to reducing the patient load of GOP doctors in order to provide longer consultation duration for each patient.

(e) Improvement of Clinic Environment and other Support Facilities

8.46. Even if there is a team of well-trained medical and nursing staff, they cannot properly perform the primary health care functions without the necessary infrastructure and supporting services. Apart from reduction in the number of cases seen, upgrading the provision of equipment, facilities and drugs in clinics as well as distribution of guidance notes, treatment protocols and drug information sheets are equally important. We recommend that necessary improvements to clinic environment and support facilities should be identified with the co-operation of doctors in the clinics and the management should respond to these needs.

(f) Re-scheduling of Appointments

8.47. To address the anomalous situation where some doctors finish seeing all the patients well before the closing time of the clinic while there are patients being turned away and the common phenomenon of patients waiting for a long time at the clinic for their turn to see the doctor, we have examined the operation of the present "block appointment" system in GOP clinics. Under this system a certain number of patients are

scheduled to be attended to within a specified time-span[23].

8.48. Having regard to the large number of patients seen in GOP clinics and the potential public demand for this heavily subsidized form of medical care, we feel that the existing "block appointment" system is the most practicable arrangement for the time being. The alternatives of a telephone appointment or a pre-booked appointment system for all patients have been discussed but these are not considered to be workable propositions until the demand issue has been adequately resolved. However, the success of the "block appointment" system depends on the co-operation of doctors and patients. We recommend that efforts should be made to motivate the doctors to make the best use of the time available for each consultation and to educate their patients to comply with the appointment schedule. In addition, we recommend that an advance appointment system be developed for patients suffering from chronic diseases who require follow-up consultation at regular intervals. Under this arrangement, GOP users with chronic diseases such as hypertension, diabetes mellitus, chronic obstructive airway diseases will be given a follow-up card indicating the date and time of the next appointment.

Use of GOP Service by Civil Servants

8.49. In reviewing the GOP service, we have noted with some concern that of the some four million doctor

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[23] For example, patients holding registration discs numbered 1 to 20 are expected to turn up between 9 a.m. and 10 a.m. and so forth.

consultations at GOP clinics in 1989, about 0.78 million or 19.4% were taken up by civil servants, retired civil servants and their eligible dependants. The service is provided free to civil servants and their dependants as part of their conditions of service. We were told that GOP clinics were supplementing the service available at two Families Clinics which were Government clinics designated for the exclusive use of civil servants and their dependants and other non-public GOP clinics operated within police and correctional institutions. Whilst civil servants are generally receiving the same standard and scope of service as other members of the public in GOP clinics, we have observed that a different mode of operation is adopted in some larger clinics for civil servants. This include the arrangements for telephone booking of appointment, the allocation of priority discs up to a quota, the designation of a special consultation room to see civil servants and the keeping of simple medical records for these patients.

8.50. We acknowledge that provision of medical care to civil servants is an employer-employee issue outside the ambit of our review. However, given the considerable proportion of GOP service used by civil servants, the undesirable effects of the co-existence of two different modes of operation in the delivery of service at these clinics and the likely impact that our recommended improvements to GOP service might have on the utilization of this service by civil servants[24],

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[24] We were told that at present the two Families Clinics are not able to cope with the demand from civil servants and a large number of eligible civil servants are not making use of the GOP clinics because of the unsatisfactory quality of service.

we hope that our recommendations in this respect would not be regarded as totally irrelevant.

8.51. Basically in this respect, the Department of Health is performing two separate roles : as the provider of primary medical care to members of the public and as Government's agent for services to fulfil its obligation towards employees. We recommend that separate accounting arrangements should be introduced within the Department of Health's overall budget so that the costs of providing primary medical care service to civil servants, retired civil servants and their dependants could be identified separately from those for members of the public. When the respective costs to Government of these two activities of the Department of Health are known, there would be a clear basis for allocating public resources in accordance with the desired objective. For example, if Government were to meet the increasing demand for primary medical care from civil servants, the Department of Health should be given additional resources specifically for this purpose. Within such an accounting framework, arrangements could then be devised to guard against any resources and benefits attained through reforms to the GOP service being diverted to meeting increased demands from civil servants. In the long run, we recommend that the Administration should give due consideration to finding alternative arrangements for providing primary medical care services for members of the civil service. Some form of employers insurance or contract-out arrangements with groups of private practitioners are possible alternatives.

Improvements to Private Sector Primary Medical Care

8.52. In order to bring about an overall improvement in primary medical care to the community, the quality of service provided by private practitioners which account for some 70% of all medical consultations should also be upgraded. This would require the adoption by private practitioners of some of the desirable practices that we have recommended for GOP clinics.

8.53. Other than encouraging doctors in private practice to improve their quality of service and facilitating such improvements by extending to them opportunities for further training, it would be unrealistic to impose particular standards on professional practice or require certain behaviour of members of the profession other than those contained in the medical profession's code of practice. In countries where there is some form of national health schemes or large scale medical group practices, the economic factors at work would help to induce some improvements in the quality of service. For example, the possession of certain postgraduate qualifications or the adoption of certain professional behaviour by the practitioners could be made prerequisites for admission into the scheme or the practice. These factors, however, do not exist in Kong Kong where some 95% of private practitioners are in independent solo practice.

8.54. We have therefore put forward in the following paragraphs suggestions for improvement to private practices. These cover areas of enhanced training and quality assurance, practice of good family medicine and public education. We are fully aware of the practical difficulties of the private sector to implement

voluntarily some of the proposals. We hope gradual improvements could come about through changes in professional attitudes, better public education and a leading role to be taken by medical associations and training institutes.

(a) Training of Doctors in Family Medicine

8.55. As private practitioners are the frontline providers of primary medical care, we recommend that like their counterparts in the public sector, they should be given more opportunities for training in family medicine. This issue is further discussed in Chapter Ten.

(b) Development of Peer Review

8.56. Review of the clinical practice of doctors by their peers or fellow doctors would help to assure the quality of service and the appropriateness of certain behaviour and habits. Peer review is the assessment of one doctor's performance by another with the mutual understanding and co-operation of the doctors concerned. The essence of review is to enable doctors to modify their clinical procedures to make them more efficient and to achieve higher standards in patient care. We recommend that the HKCGP and the medical associations should play an active role in encouraging peer review as in the case of their counterparts in the United Kingdom and Australia.

(c) Promotion of Group Practice

8.57. Opportunities for further training and peer review would be more easily available in group practice

than when doctors are practising single-handedly. The costs of opening and maintaining a solo practice, especially by a young doctor, are said to have resulted in the highly entrepreneurial and competitive nature of private practices in Hong Kong. The quality of service inevitably suffers when the doctor has to take on a heavy patient load. This may also induce the adoption of certain clinical behaviour such as prescribing drugs for a short period and encouraging repeat visits which may not always be to the benefit of the patient. Group practice, on the other hand, reduces the overhead costs, enables sharing of resources and equipment so that complex diagnosis and management could be carried out more in the clinic, facilitates doctors to take leave to undergo training and provides doctors with the opportunity to share their professional expertise and review each other's activity. We recommend that group practice should be promoted in Hong Kong and the arrangements for collaboration between the public and private sectors, discussed in the latter part of this chapter, should facilitate such a development.

(d) Enhanced Communication between General Practitioners and Specialists

8.58. Like the public sector, a great deal of referral activities take place in the private sector between general practitioners and their colleagues practising in various specialties. Good communication and co-ordination between general practitioners and specialists is conducive to providing quality care for patients. We recommend that private practitioners in primary and specialist care should maintain a close liaison and ensure an adequate two-way flow of information when patients are referred.

(e) Improvement to Medical Records

8.59. Although the quality of medical records varies, virtually all private practitioners maintain individual medical records for their patients. We recommend that private practitioners should keep good medical records and give a detailed explanation to patients of their specific medical problems. Greater understanding about one's health will promote better compliance with the recommended treatment and increase confidence in the doctor. This should help to reduce the tendency of patients shopping around for doctors which is at present a very common practice. Consideration should also be given to maintaining and updating those records with the aid of personal computers.

(f) Labelling of Dispensed Medicines

8.60. We recommend that private practitioners should adopt the practice of labelling dispensed medicines. If progress is unsatisfactory, the alternative of making labelling of dispensed medicines a statutory requirement should be considered by Government. The tendency, among many, of buying drugs over the counter is well recognized. Compulsory labelling of dispensed medicines must therefore be accompanied by better control over the sale of drugs over the counter as governed by provisions in the Pharmacy & Poisons Ordinance.

(g) Counselling and Education of Patient

8.61. The clinical behaviour of doctors and the style of delivery of service such as polypharmacy and over-prescription are to a certain extent affected by

the patients' perceptions, expectations and demand for care. While education of patients towards proper maintenance of health can take the form of mass public education programmes undertaken by agencies such as the CHEU, doctors are in the best position to educate and counsel their patients on an individual basis on matters related to the management of their health problems. Patients are more susceptible to health advice when they are sick and seek medical consultation. The impact that doctors could have on educating their patients should not be overlooked. We recommend that private practitioners should give greater priority to providing promotive and preventive health care and counselling to their patients.

Collaboration between Public and Private Sectors

8.62. One of our terms of reference is "to examine the respective roles of the public and private sectors and the educational bodies with the aim of achieving better co-ordination and co-operation among these sectors in the overall development of primary health care in Hong Kong". The role of educational bodies is discussed in our deliberations on training and health services research. The following section addresses this term of reference in relation to the private sector.

8.63. We recognize that private practices are free enterprises and in a free economy like Hong Kong, it would not be appropriate to achieve improvements through unilateral regulation or control in addition to the existing disciplinary regulation of the professional conduct of practitioners by the Medical Council of Hong Kong. Improvement to the overall quality of primary medical care in the private sector can come about

through ensuring the quality of entrants into the private sector[25] and monitoring the quality of those already in the practice. Whilst the medical schools of both universities are placing increased emphasis on training in family medicine in their undergraduate courses and the HKCGP is promoting quality assurance among its members, the expected improvements from these measures would only come about in the long run. To introduce some early improvements to the quality of primary care provided by private practitioners and to achieve a truly collaborative approach to primary health care in the future, we are putting forward possible arrangements for collaboration between the public sector and the private sector. **As a matter of principle, such forms of collaboration should give due emphasis to standards of care and should not involve Government subsidizing private practices.**

Clinics involving collaboration with the private sector

8.64. One such arrangement is to contract out the operation of public clinics to doctors in the non-government sector. Under this scheme, a Government clinic would be contracted out to agents of approved standards who would be required by contract to provide primary medical care service for people in a defined area. These agents could be non-government health organizations or groups of private practitioners. People within that area could use the service or other

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[25] Hence our emphasis on undergraduate and postgraduate training in family medicine in our discussions in Chapter Ten.

private doctors at cost if they wish but there would not be other public primary medical care facilities in the vicinity. Government would provide the clinic premises and other basic equipment and facilities at a rent; it would also stipulate conditions on the scope of service and standard of practice. For members of certain target groups, Government could contract with the clinics to provide subsidized primary medical care for these people either on a fee-for-service or capitation/contract basis. The other contracting party would run the clinic, employ the supporting staff, pay the recurrent expenses, provide services to Government subsidized patients as well as their own private patients who have to pay the doctors at the normal rates. The important features in this clinic are autonomy in operation, management and disbursement of funds. This clinic could also take part in insurance-based or welfare-based contract medicine. Other desirable features of a good primary care clinic could also be built into the contract. These could include collation of epidemiological data, keeping of good medical records and providing training ground for medical students.

8.65. The advantages of this scheme are :

(a) **Better quality assurance** : this mode of operation provides more direct opportunities for better quality assurance of primary medical care rendered to the community while service provision remains largely in the hands of the private sector. These clinics would have to be under the oversight of Government to ensure that the operators are complying with the contract conditions.

(b) **More cost-effective service :** each contracted clinic would enjoy a high degree of autonomy, plan and control its own budget. It would not be subject to rigid centralization in the acquisition and deployment of resources as in the case of Government clinics. Operating as a cost centre of its own this would facilitate the provision of a more cost-efficient service.

(c) **Improved clinic environment and incentives for training :** by incorporating some of the desirable practices that we have recommended for private doctors into the contract conditions, this would create a clinic environment conducive to the practice of good family medicine and incentives for doctors to acquire further skills and knowledge in family medicine. These doctors would be in a better position to interact with specialists in hospitals and specialist clinics especially those located within the same district.

(d) **Wider choice of primary care :** these clinics would provide the community with an additional choice to low-charge and hence low-expectation care at GOP clinics and private practices offering variable standards of care. While those who can afford to pay would have to pay more for a medical consultation at these clinics than at a Government clinic, they would be receiving a quality service provided by well-trained doctors.

(e) **Exemplary effect on other private practitioners** : improved practices in these clinics would have an exemplary effect on other private practitioners, especially those operating in the vicinity competing for the same group of clients. Hopefully, this scheme may bring about similar improvements in other private practices.

8.66. On the other hand, the perceived disadvantages of this scheme are that such clinics contracted to private practitioners would no longer provide an open access to a low-charge service for **all** as in the case of the present public clinic system. However, Government will continue to bear its traditional responsibility to provide subsidized medical care to those in need. Arrangements would be devised to ensure that the needy could continue to receive subsidized care.

8.67. Others may worry about public funds being diverted to subsidizing private practice under this scheme. Regarding this point, we are aware that what we have presented is only a conceptual framework. To put this idea to test, a great deal of administrative preparation work and negotiations with agencies or groups of practitioners who have a potential interest to participate in the scheme would have to be undertaken. The issues of setting the level of fees, ensuring coverage for needy groups who require subsidized medical care while avoiding duplication in the provision of subsidized services and monitoring the performance of the contracting party would have to be adequately addressed prior to implementation.

8.68. Furthermore, there may be opposition to such a scheme from doctors in private practice, especially those who have an established practice in the vicinity of the contracted-out clinic. We therefore recommend that the proposed clinics for collaboration should be developed on a pilot basis involving one or two clinics, preferably in a fairly newly developed and geographically isolated area. We have identified Ma On Shan and Tin Shui Wai as suitable locations. These sub-districts are relatively isolated; GOP clinics have been planned to meet population needs but are not yet in operation.

8.69. One possibility to implement the above scheme which we have considered, though not in detail, is to build on the existing mechanism in EDA clinics that we have described in paragraph 8.17. A similar arrangement, but with the clinics grouped to form one unit, with post-qualification requirements for the practitioners and with a service contract could form the basis for developing such clinics. In due course, if successful and with the agreement of the Housing Authority and the EDA, similar arrangements could come into force for new or vacated EDA clinics.

Scheme based on primary medical care insurance

8.70. We are aware that an insurance scheme providing only primary medical care would not be as profitable and viable as one encompassing primary medical care and hospital care or on hospitalization. It is also less attractive to individuals paying out-of-pocket as they are more ready to buy insurance for catastrophic illnesses than minor ailments. Such a scheme therefore has to be doctor-based rather than

insurer-based and has to involve contribution from employers.

8.71. Under this scheme, employers would pay an agent a premium based on the number of people they employ to cover the primary medical care of their employees and/or their dependants [26]. This agent would in turn contract with a panel of doctors to provide primary medical care to those enrolled with the scheme. To keep administrative costs low in order to increase attraction to employers, we consider that such a scheme should be run by a non-profit-making organization which should be represented by all the parties involved : the doctors as providers of the service, the patients as consumers, the employers and the Government if it is going to assume a regulatory role over medical insurance schemes or to give some support to facilitate the setting up of such an organization.

8.72. The merits of this scheme lie in its potential ability to raise standards in private practice since one of its important features could be that only doctors with certain postgraduate qualifications or those who pledge to undergo further training in family medicine would be able to participate. The non-profit-making organization would be in a position to monitor closely

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[26] According to estimates based on the experience of currently run insurance schemes made available to us, the annual cost at current prices would be approximately $800 to $1,000. No doubt this cost would vary depending on the size of people covered in the plan and the type of exclusions in the services provided.

the activities of doctors including their recall patterns and prescribing practices. The data collected from these practices would form a very useful epidemiological data bank and in the long run, could be integrated with whatever health information system to be developed by the Department of Health. Another advantage of this scheme is the likely encouragement that it could have on employers' insurance on a **voluntary** basis. The operation of such a scheme by a non-profit-making organization would certainly be more attractive to employers who are already conscious of the need to provide medical benefits for their staff.

8.73. It has been suggested that to facilitate the introduction of such a scheme, Government should consider providing a loan to the non-profit-making organization to finance the setting up costs. However, we consider that any Government involvement in private insurance schemes must be seen in the overall context of the future policy on health care financing and the direction we are moving in on the development of medical insurance. These issues are addressed in Chapter Fourteen on Financing of Health Care Services in which we have concluded that it is opportune for a study on the overall policy on health financing to be conducted. Therefore, while we have put forward the above scheme as a possible means to improve quality of services in private practices, for the time being, this should remain a private sector initiative on the basis of voluntary participation of employers.

Co-ordination between Out-patient Clinics and Hospital Services

8.74. We are required by our terms of reference to examine two particular aspects which are directly

related to hospital services and the Hospital Authority -

(a) to suggest arrangements to strengthen the co-ordination between the out-patient clinics and the hospitals including the issues of keeping patients out of hospitals and encouraging ambulatory care; and

(b) to consider whether general out-patient services and any other aspects of primary health care should be brought under the Hospital Authority.

8.75. We shall address the second issue in Chapter Twelve on the preferred structure for the future delivery of primary health care services. The rest of this chapter contains our arguments and recommendations on the various issues of co-ordination between hospitals and primary health care services and in so doing, we have given careful consideration to recommendations from PHA.

Approach to Co-ordination

8.76. In Hong Kong and in many other countries, inadequate or poor quality primary health care services have too often been held responsible for overcrowding in hospitals and long waiting times in specialist clinics. It is, however, ironical to note that despite this common belief, primary health care has seldom been given the generous resources that have been extended to hospitals. Primary health care encompasses a wide range of preventive, promotive, curative and rehabilitative services. These services should be able to provide

those who have fallen ill appropriate curative treatment or referral to secondary or tertiary medical care. The primary health care setting should also be equipped to take care of these patients again when their conditions have been stabilized.

8.77. As a fundamental principle, we consider that issues of co-ordination between hospital services and primary health care services should be addressed with the aim to promote primary health care for the benefit of the patient rather than as a cheap means to alleviate overcrowding in hospitals.

8.78. Apart from an imbalance in resource allocation, efficient co-ordination between hospital and primary care services is also handicapped by the lack of trained personnel in the primary health care field. Doctors who have neither vocational training in family medicine or continuing medical education nor proper supervision would not be confident enough to take care of the patients themselves and would tend to refer patients to their specialist colleagues. By the same token, doctors in hospitals are reluctant to discharge their patients to be cared for in general clinics, whether in the public or private sector.

Appropriate Mode of Co-ordination

8.79. Co-ordination between primary health care and specialist care whether in the hospitals or specialist clinics should be a **two-way flow.** In normal situations, the flow takes place when a primary care doctor diagnoses or suspects an ailment in a patient's conditions which requires expert advice and therefore refers him for consultation or treatment in specialist

clinics or hospitals. After the necessary specialist treatment has been given and the patient's conditions stabilized, he or she should be referred back to the primary care doctor for continuity of care.

8.80. Suitable timing is of significance in the referral system. A patient should not be referred to a specialist at too early a stage when the illness can still be properly taken care of by primary care doctors, nor too late when the disease may have advanced. Timing is also essential in the referral backwards from hospitals or specialist clinics to the primary care doctors. Good timing would ensure better utilization of both primary care and specialist resources.

8.81. To ensure that there would not be unnecessary delay in treating the patient's disease, nor would there be a waste of resources, it is essential that referrals from primary health care be made to the appropriate specialty and where the necessary facilities are available.

Improving the Referral System

8.82. A first step to improve co-ordination between primary health care and specialist care is to equip primary care doctors with the skills and knowledge to adequately perform the role of a referring doctor. In this respect, we recommend that primary care doctors should be provided with the necessary basic training, exposure and experience in various medical specialties so as to enable them to be more competent in handling patients and in determining the appropriate time to refer patients to the appropriate specialist service. Such training may be provided by attaching primary care doctors to the major specialties in hospitals as part of

their vocational training[27]. However, the orientation and emphasis in these training programmes must be tailor-made according to the needs of good family medicine, which may differ quite substantially from postgraduate training for specialists.

8.83. On the other hand, we also consider it desirable for specialists working in hospitals and specialist clinics to perform part-time service at the primary medical care setting. This arrangement would have the advantages of enhancing mutual understanding between providers of health services at the primary and specialist levels, providing professional support to primary care doctors especially at the initial stages when most primary care doctors have yet to undergo further training and helping to reduce referrals to the specialist sector. Whilst specialist clinic sessions providing chest, skin, eye and ENT services are currently provided in some GOP clinics, we recommend the setting up of additional specialist mini-clinics on a sessional basis at GOP clinics to be run jointly by specialists from hospitals and GOP doctors. The development of follow-up clinics for patients suffering from chronic diseases or adoption of special management protocols for these patients would also help to reduce referrals to the specialist sector.

8.84. Any referral to and from one sector would only be meaningful if there is good communication between the two sectors. This is at present hampered by the lack of

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[27] The desirable contents of vocational training for doctors in family medicine is discussed in Chapter Ten.

medical records at GOP clinics. We recommend that with the introduction of medical records for individual patients at GOP clinics, referrals to specialist service should be accompanied by a written report containing as much details as possible on the patient's medical history and the referring doctor's observations and diagnosis. Likewise, the specialist doctor should also make available to the primary care doctor a report on the treatment rendered to the patient and his present conditions and needs for follow-up treatment in referring the patient back to the primary care setting[28]. In addition, the referring specialist should continue to work in co-ordination with the GOP doctor and provide the necessary support. Consideration should also be given to standardizing the format of these reports.

8.85. When specialists in hospitals or specialist clinics discharge the small group of patients who are no longer suffering from complications and who may be adequately taken care of in the primary care setting, these patients should generally be referred back to their referring doctor, whether in the public or private sector. In practice, we are aware that most of them are referred to GOP clinics for follow-up care, irrespective of whether they are initially referred from private doctors or from the Accident and Emergency Departments. As a result, GOP clinics are accumulating a large number of recurrent patients with chronic diseases who require

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[28] According to the Director of Health's survey of GOP doctors, 70% of respondents reported that feedback was received from specialist clinics while only 30% reported receiving feedback from hospitals.

long-term continuing treatment[29]. We agree that provision of continuity of care to patients suffering from chronic diseases fall within the curative and rehabilitative components of primary health care. However, the expanded role of GOP clinics in this respect should be properly reflected in the allocation of resources. We recommend that additional resources be given to GOP clinics to take care of the increasing number of patients referred to them for follow-up care from the specialist services. By the same token, where certain services or procedures such as endoscopy can be provided in the primary care setting, the necessary resources should be made available in order to take away some pressure from the specialist clinics which are said to operate on long waiting lists.

Our Response to PHA's Proposals

8.86. The PHA has recommended five main areas to strengthen and improve co-ordination between out-patient clinics and the public hospitals[30]. We have

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[29] This is confirmed by the experience of the four pilot clinics where individual patient medical records have been introduced. The records indicate that 70% to 80% of patients are frequent users of the clinic and 30% to 50% of these frequent users are patients who require regular and long-term follow-up for chronic conditions.

[30] A full submission of the Provisional Hospital Authority to the Working Party is contained in Chapter 14 of the PHA Report, December 1989. The various arrangements recommended by PHA to improve co-ordination between hospitals and out-patient clinics are reproduced at Appendix 16.

carefully considered these suggestions in the context of our recommended approach to co-ordination.

8.87. The PHA has recommended that referrals from GOP clinics should be made to specialist clinics with the shortest waiting times through an information system. We endorse the need for enhanced co-ordination but feel that the benefits to be gained from referring patients to specialist clinics with the shortest waiting times would only be marginal, when the location of workplace/residence and age and conditions of the patients and the administrative costs of separately setting up an information network specifically to facilitate referrals of this sort are taken into account. However, with the development of a computerized clinical information system in the GOP service which should link up with other clinics[31], the PHA proposed arrangement would be possible.

8.88. The above recommendation of PHA seems to suggest that GOP clinics are a major source of referrals to specialist clinics. This is not substantiated by the HKU GOP Survey[32]. The problems of heavy pressure on

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[31] The development of a clinical information system is discussed in Chapter Five, paragraphs 5.58 - 5.60.

[32] The survey analysed the referral patterns of the sampled GOP clinics and their likely impact on specialist services. Referral rate to specialist clinics was 4.91% and the contribution of GOP clinics to the work of specialist clinics was estimated to be 7.9% of the workload of specialist clinics, excluding return visits to these clinics.

specialist clinics and long waiting times can only be adequately addressed by examining the referral patterns from other sources such as private practitioners as well as the operation of the specialist clinics. We recommend that a study into the operation of specialist clinics should be accorded priority by the Hospital Authority.

8.89. The PHA has considered multi-disciplinary training for GOP doctors to be desirable and has suggested that this be achieved by attaching GOP doctors to various specialties in hospitals and vice versa. We fully share this idea and shall discuss in Chapter Ten hospital training programmes for GOP doctors. In our view, the orientation and emphasis in hospital training for primary care doctors through rotational attachments should not simply follow that of specialists in hospital service but should be adjusted according to the needs of family medicine. Like PHA, we consider it desirable for specialists working in hospitals and specialist clinics to have exposure to the primary medical care setting through taking up sessional appointments in specialist mini-clinics in GOP clinics which we have proposed in paragraph 8.83.

8.90. The PHA has recommended that the utilization of GOP clinics should be increased, say, by providing a 24-hour service so as to ease the demand for accident and emergency services. Whilst we appreciate the need to reduce attendances at Accident and Emergency Departments in the hospitals, we doubt the cost-effectiveness of operating some GOP clinics round-the-clock. It would be counter-productive if patients requiring genuine emergency treatment turned up at these GOP clinics where a full range of investigation

and supporting facilities was lacking. The idea of adjusting the operation of GOP clinics simply to relieve pressure on the Accident and Emergency Departments generated by episodic cases also deviates from our recommended objective for Government primary medical care at GOP clinics : that they should aim to provide family medicine service to patients with emphasis on continuity of care. We consider it more effective to have good family practice in place both in the public and private sectors so that in an ideal situation, patients suffering from minor illnesses in the middle of the night could call up their own family doctor for advice and reassurance until the primary medical clinics open. Health education on the treatment of minor ailments would also assist in this regard. In cases of real emergency, the use of the Accident and Emergency Department would be appropriate.

8.91. The PHA has suggested that in order to reduce the need for hospital attendance, "day beds" should be introduced in GOP clinics to enable the conditions of patients whose need for hospital admission cannot be ascertained in the first instance to be observed. The list of minor operations and medical procedures that can be carried out in GOP clinics should also be expanded. We agree that family practitioners should receive proper training in the surgical techniques that can be performed in the primary medical care setting. In the long term, investigations such as endoscopy and ultra-sound should also be performed in the primary care setting and consideration should be given to extending primary care to include some specialized services such as opthalmology and optometry. However, we do not agree that "day beds" for observation purposes should be introduced in GOP clinics. This proposal would not be

justified given the profile of present GOP users and the low referral rate from GOP clinics to hospitals[33]. Such facilities should be more appropriately situated in hospitals.

8.92. We agree with the PHA's recommendation that there should be a close link between accident and emergency medicine and primary health care and that the increased use of observation beds in Accident and Emergency Departments should be considered.

8.93. Finally, we wish to echo the PHA's call for a close working relationship between the Hospital Authority, its Regional Advisory Committees and individual public hospitals with the Department of Health. We believe that the District Health System outlined in Chapter Eleven would go some way towards meeting this objective.

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[33] According to the HKU GOP Survey, admission rates to hospitals from GOP clinics via the Accident and Emergency Departments were estimated to be between 2.1% and 4.2%. Such GOP referrals were responsible for between 1.3% and 2.6% of all hospital admissions.

CHAPTER NINE

COMMUNITY HEALTH SERVICES AND REHABILITATIVE CARE

Introduction

9.1. We are required by our terms of reference to address the issues of keeping patients out of hospitals and encouraging ambulatory care. Apart from preventive care and health promotion activities, rehabilitative services are pertinent to keeping patients out of hospitals. Many of these rehabilitative services should preferably be provided in the home environment rather than in institutions. This is particularly relevant in a Chinese community like Hong Kong where the family remains the major support unit. This chapter discusses the provision of community health services with particular emphasis on rehabilitative care.

9.2. First of all, we should point out that community health services and ambulatory care should be provided on the basis of an **integrated** approach. They rely on the co-ordination and co-operation of health workers, social workers, neighbours as well as families and individuals. The objectives to keep patients out of hospitals and to encourage ambulatory care cannot be achieved by health services alone. Secondly, provision of community health services should not and need not be confined to the Government sector. In fact, many of the existing community health services were pioneered by non-government organizations which are generally in a better position to introduce more

innovative approaches to health care than a government bureaucracy. This is particularly the case for district-based non-government organizations which are more clearly aware of the needs of the community and are able to mobilize support of volunteers within that community.

9.3. Many of the community health services that we have reviewed are currently not operated or funded as primary health care services. Community nursing service, domiciliary occupational therapy service and hospice care are hospital-based services the provision and development of which are regularly reviewed and monitored by HSD and the relevant advisory bodies. For this reason, we have concentrated our discussion on the objectives, scope and nature of these services in the context of primary health care to see whether changes are necessary. We are pleased to note that many of our proposals in this respect are consistent with the findings and recommendations of separate reviews conducted simultaneously by other bodies. These include the review of CNS and hospice care service by MDAC and the review of DOT service by the Rehabilitation Development Co-ordinating Committee.

Community Nursing Service

9.4. Community nursing service is currently a hospital-based rather than a community-based service provided by HSD and a number of non-government organizations under medical subventions. In 1988/89, 12 410 cases were served by CNS and the total number of home visits made was about 232 200. According to HSD's analysis, 84.5% of the cases were referred from hospitals, 8.4% from out-patient clinics and Accident

and Emergency Departments and the remaining 7% were from other sources including general practitioners in the private sector. The two major groups of CNS clients are postnatal mothers and the elderly with chronic diseases or physical disability. In 1988/89, postnatal mothers accounted for about 40% of the total cases, most of them requiring only a few visits by community health nurses. Between 35% to 40% of the CNS patients were aged 65 and above and most of them required more frequent visits.

9.5. The original objectives of CNS as endorsed by MDAC are -

(a) provision of domiciliary medical and surgical nursing care and treatment to patients discharged from public hospitals;

(b) provision of nursing care in the treatment and rehabilitation of geriatric and handicapped patients in the home environment; and

(c) education and motivation of the patients and their families to encourage participation in the treatment process and in all matters pertaining to the patients' medical and health care, including knowledge of general hygiene, home management, dietary advice and prevention of accidents.

By providing domiciliary nursing care to qualified discharged patients, CNS helps to reduce pressure on hospital beds and to alleviate overcrowding in public hospitals.

9.6. Our deliberations on CNS have the benefit of input from a working group set up in late 1989 under the Community Nursing Service Joint Consultative Committee[1] to review the service and to consider its future development within the context of a comprehensive health care system. This working group has identified three main areas of inadequacy -

(a) inadequate communication with doctors which affects referral to the service and follow-up care for patients;

(b) insufficient co-ordination of care for patients : inadequate medical and paramedical support and advice on special care areas; and

(c) inadequate post-basic training for community nurses and a shortage of opportunities for continuing in-service education.

9.7. We agree generally with the observations of the working group and consider that to address these areas of inadequacy, objectives of the service should be re-defined and the scope of service more specifically defined. The client groups to be served should also be broadened from patients discharged from

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[1] The Community Nursing Service Joint Consultative Committee is chaired by a Principal Medical Officer in HSD and comprises HSD's nursing officer in charge of CNS and representatives from other agencies providing CNS. It serves as a central forum for addressing common issues of concern including issues of staff training.

hospitals to all patient-clients in need even though in places where home nursing service is district or community-based, as in Singapore or Australia, the majority of clients are still patients discharged from hospitals. Whilst emphasis should continue to be placed on curative and rehabilitative aspects, the preventive and promotive role of CNS, say, in educating the patients and carers in the family in the rehabilitation and health maintenance of patients should be strengthened. In consultation with the working group and having made reference to the Royal District Nursing Service in Melbourne, Australia, we recommend that the objectives of CNS should be re-defined in the form of a mission statement, a set of service objectives that would facilitate evaluation and a more clearly defined scope of service. We are aware that these revised objectives have also been endorsed by MDAC at its meeting in July 1990.

Mission Statement

As an integral part of the total health care delivery service, Community Nursing Service provides quality nursing services to people in their own environment, usually the home.

Objectives

(a) To provide quality, comprehensive, individualized and continuing nursing care for patient-clients in need in their home environment;

(b) to provide nursing care aimed towards maximizing self-care by patient-clients

themselves and positive resolution of their health care problems;

(c) to promote the participation of carers or family members in the treatment or rehabilitation process of patient-clients;

(d) to ensure effective communication with other members of the health care team to facilitate the co-ordination of services and co-operative working relations with personnel from other community agencies; and

(e) to develop quality nursing service through training and continuing education for community nurses at all levels.

Scope of Service

(a) Home Nursing Care - to provide patient care by means of skilled individual nursing care to patient-clients and families. This includes simple clinical observation, basic wound care, bedsore dressing, administration of drugs and injections, Ryles' tube feeding, maintenance rehabilitative exercise, basic home adaptation and postnatal care.

(b) Special Nursing Care - to identify health care problems in the community and provide special care programmes for patient-clients. This includes stoma care, hospice care, incontinence care, home respiratory care, Continuous Ambulatory Peritoneal Dialysis (CAPD) care, geriatric assessment and diabetic care.

(c) Health Education - to provide individualized health education to patient-clients and carers and group health education in elderly centres.

(d) Consultation - to provide consultative services to support and assist nursing and paramedical staff and carers in addressing complex problems in families in need of care.

(e) Liaison and Co-ordination - to refer or liaise with agencies to provide support services to enable the effective delivery of nursing services to the community.

9.8. Bearing in mind that no alternatives to the type of service provided by community nurses are readily available, except employment of private nurses at considerable expense, we recommend that CNS should continue to be universally accessible. However, to avoid abuse and to make the best use of resources, the present practice of some form of medical assessment in support of referral to CNS should be maintained and the possibility of an appropriate scale of fees should be considered[2].

9.9. Apart from the objectives and scope of service, we have also addressed the issue of how CNS should be organized in terms of structure. Our terms of reference have required us to consider whether the GOP service and any other aspects of primary health

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[2] The issue of charging for CNS is discussed in Chapter Thirteen on Funding and Implementation.

care should be brought under the Hospital Authority. This we have done in Chapter Twelve. Vice versa, we have considered whether certain aspects of the current system of hospital services should be incorporated into the primary health care system.

9.10. Regarding CNS, we have considered the advantages and disadvantages of organizing CNS under the primary health care services put forward by members of the working group of the CNS Joint Consultative Committee[3]. We consider that technical and staffing problems aside, the advantages of organizing CNS as a community-based service outweigh the disadvantages. This particularly would be the case with the re-orientation of the service towards meeting community needs and promoting health education and our recommendations on district health teams. Community nurses have an important function to perform in these future district health teams. As part of the community-based service, community nurses would be able to interact with other members of the health care team and obtain more direct professional support from the primary care doctors. We therefore recommend that CNS should be organized as a primary health care service and that this arrangement should be introduced on a pilot basis in the two primary health care districts to be set up[4]. However, as the majority of CNS

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[3] A summary of views expressed by members of the working group of the CNS Joint Consultative Committee on organizing CNS as a community-based service is at Appendix 17.

[4] Discussion on the two primary health care districts is contained in Chapter Eleven.

clients are patients discharged from hospitals who may require specialist care, the re-organization of CNS on a community basis should not preclude community nurses from seeking support and advice from specialists in hospitals or specialist clinics. As in the case of improved co-ordination between GOP clinics and hospitals which is discussed in Chapter Eight, liaison between CNS, family physicians and specialists should also be strengthened.

9.11. Our attention has been drawn to potential staff problems arising from such a structural change as CNS, which is now hospital-based, would be operated under the Hospital Authority. Although this issue on staffing arrangement is for the Administration to address, we do not think it would create insurmountable problems.

Community Rehabilitative Service

9.12. Community rehabilitative services currently provided for the disabled comprise domiciliary occupational therapy service and to a very limited extent, domiciliary physiotherapy service provided mainly by the non-government sector. Their objectives are to provide advice and assistance to persons suffering from physical or mental disabilities as well as mentally ill patients who face adaptational problems in their normal daily living at home or at work after discharge from hospitals.

9.13. In the government sector, DOT is provided by HSD as part of its centre-based occupational therapy service. In the non-government sector, both the Spastic Association of Hong Kong and Rehabaid run a DOT

service for disabled clients in the community. Unlike HSD's service, the DOT service provided by these agencies recruits its clients directly from the community. There is also a greater emphasis on counselling, advice and education. As for domiciliary physiotherapy service, we are aware that this is now provided on a limited scale by the non-government sector such as the Yang Memorial Social Service Centre.

9.14. Domiciliary rehabilitative services are a form of ambulatory care. They are similar to CNS in the sense that they provide in the community setting care in treatment, rehabilitation, education and motivation of patients and their families. The health maintenance elements of the service helps to prevent the disabled from relapse into sickness and hence reduces the need for hospitalization.

9.15. Simultaneous with our deliberations, the Commissioner for Rehabilitation has convened an ad hoc group to examine issues related to the DOT service. Its findings and recommendations have been accepted by the Rehabilitation Development Co-ordinating Committee. These cover service objectives, projection of demand for the service, medical back-up and referral system, the planning ratio of one occupational therapist for 500 visits per year, organization, fees and charges, the evaluation criteria and the extension of government subvention to the two agencies mentioned in paragraph 9.13 currently providing DOT service.

9.16. In our view, DOT service has an important role in encouraging ambulatory care. We recommend that the development of DOT service should be promoted and

active consideration should be given to the development of an integrated domiciliary rehabilitation team comprising DOT, physiotherapy and other paramedical services. Like CNS, DOT service should become an integral part of primary health care in which the occupational therapist would work closely with other members of the health care team under proper medical supervision and with continued back-up support from in-patient OT service. However, in the interim, the structural issue should not prevent appropriate financial support being extended to this service, especially that provided by the non-government sector. A developed DOT service would provide a source of support and assistance to CNS in ensuring comprehensive and integrated care for patient-clients in their home environment.

<u>Hospice Service</u>

9.17. Hospice care is a total package of palliative care for the terminally ill, including emotional, spiritual and medical support for the patient and his family. It is intended to enable patients to remain comfortable in their home environment for as long as possible, to provide the best possible symptom control and a dignified end, and to give support to the bereaved family.

9.18. At present, hospice care is provided in five subvented hospitals with either designated bed support or simply a home care programme. In government hospitals, a limited service is provided by a voluntary visitation programme at the two radiotherapy and oncology units at the Prince of Wales Hospital and the Queen Elizabeth Hospital. Hospice care has also been

incorporated into the training programme of CNS since 1988. The community nursing service now accepts referrals for palliative care to needy patients at home, with the main emphasis on trying to lessen the severity of pain to the patients.

9.19. We support the recent MDAC recommendation that hospice care should be developed in Hong Kong and welcome the formation of a Co-ordinating Committee on Hospice Care Service to co-ordinate the efforts of the various organizations providing hospice care and to advise the Secretary for Health and Welfare on the development, training and resource requirements of the service.

9.20. Hospice service is more than medical or nursing care alone or the combination of the two. It also goes beyond curative and rehabilitative services. Voluntary care and support provided by friends and relatives of the patients, religious personnel and the community are equally important. While we have concluded that hospice service does not fall entirely within the scope of primary health care, we consider that CNS could be further developed in the area of providing nursing attention and palliative care to patients at home. In developing hospice service, greater emphasis should be placed on the home care programme with the full participation of the family.

Community Health Service for the Elderly

9.21. The issues of keeping patients out of hospitals and encouraging ambulatory care are particularly relevant to the elderly. It has been said quite often that public hospitals are the dumping

ground for elderly patients whose family is either unable or unwilling to take care of them. This certainly goes against the time-honoured virtues in a Chinese community of respecting the elderly and looking after the older members in the family.

9.22. The health and well-being of the elderly cannot be achieved by the health sector alone. In the Draft White Paper on Social Welfare into the 1990's and Beyond[5], it is acknowledged that "there is a clear need for a better interface between the elderly services which fall within the programme area of the Social Welfare Department and other services such as hospital services, primary health care, housing, transport, etc." The following section consolidates our discussion on community health services for the elderly, some of which may have already been addressed in greater detail in the preceding chapters on health promotion, preventive care, health screening and clinic services. These services should as far as possible be complementary to and integrated with community support services provided by the social welfare sector.

9.23. In our discussion on community health services for the elderly, elderly persons are defined as those persons aged 65 years and above. This reflects the current definition of the elderly used in health services although the age of 60 years is used in the welfare sector.

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[5] This draft White Paper published in September 1990 was prepared by the Working Party on Social Welfare Policies and Services and was the subject of public consultation when we were drafting our report.

9.24. In mid-1989, there were a total of 490 000 people aged 65 and above, representing 8.6% of the total population (5 713 700) in Hong Kong. These figures show that the size of the elderly population has increased by 19.9% since the March 1986 by-census while the overall population has grown by only 6%. According to population forecasts, the proportion of the population over 65 years of age will further increase to 730 600 or 11.6% by the year 2000[6].

Health Needs of the Elderly

9.25. Although comprising only 8.6% of the total population, people aged 65 and above accounted for 21.5% of all GOP attendances as shown in the recent HKU GOP Survey. In the case of utilization of hospital services, patients aged 65 and above accounted for 33.7% of all admissions. In an enquiry on doctor consultation conducted via the General Household Survey in January 1989, a much higher frequency of doctor consultation was noted for those aged 65 and over, being 200 per 1 000 as compared with the overall average of 131 per 1 000 population.

9.26. In addition, there is a substantial demand for institutional services for the elderly in poor health or those suffering from permanent disablement. The needs of those requiring limited nursing care are met in C&A homes while others in need of constant

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[6] The corresponding figures for people aged 60 and above are 722 200 (12.6% of the total population) in mid-1989, projected to rise to 974 500 or 15.4% by the year 2000.

nursing care and limited medical attention are accommodated in infirmaries. There is at present an acute shortage of both types of facilities : as at 1 May 1990 the central waiting list for C&A places maintained by SWD registered a total of 8 751 persons while a total of 2 077 persons were registered on the central waiting list for infirmaries maintained by HSD.

9.27. With advances in medical technology and better health care, our elderly people are now enjoying a longer life. According to the projection in 1988, a 65 year old female can now expect to live up to 83.6 years old and the male to 80.3 years old. The progressive increase in the elderly population aggravates the demand for health services as they are the high-risk population in experiencing illnesses. Taking into consideration the need to promote quality of life of the elderly and reduce their dependence on hospital services, we strongly recommend that the elderly should be one of the most important target groups for receiving primary health care. From a purely economical perspective, maintaining and promoting the health of the elderly is cost-effective having regard to their demands on the more expensive institutional services and hospital care.

Approach to Health Care for the Elderly

9.28. In many places including Hong Kong, the responsibility of caring for the health of the elderly is shared by government and their family members, with the majority of the health costs being borne by the public purse. To reduce the elderly's overdependence on hospitalization, community-based medical and nursing

care services have been developed by many countries which have a large proportion of the elderly. We believe that provision of community health services under the primary health care system involving a range of preventive, promotive, curative and rehabilitative services will help achieve quality care for the elderly and more efficient use of resources.

9.29. Whilst it has been generally accepted that the fundamental objective of services for the elderly is to promote their well-being through care in the community and by the community, we feel strongly that it should be the responsibility of everyone to help meet their growing and changing needs : the family, the government and the elderly themselves. In particular, greater emphasis should be placed on the responsibility of the family.

9.30. In the course of our deliberations, we made reference to the position in Singapore regarding provision of health care services for the elderly. By comparison, Singapore has a younger population. The proportion of its population over 60 years of age was 220 900 or 8.3% in 1988. This is expected to increase to 332 400 or 11.1% by the year 2000. In recognition of the ageing of the population and their prominent health needs, a Health Services for the Elderly Department was established in 1985 in the Primary Health Division within the Ministry of Health. Much of the work of this department is carried out through the Home Nursing Foundation, a voluntary organization providing community-based care for the elderly. The Working Party delegation was particularly impressed by the emphasis placed on mobilizing public support and involvement in the care for the elderly and felt that such an approach should be promoted in Hong Kong.

Goal and Objectives

9.31. We recommend that a more integrated approach to providing community health services for the elderly should be adopted under the primary health care system with the following as its mission statement -

> " To promote the health and well-being of the elderly through provision of community-based services, with the maximum participation of everyone including the elderly themselves."

9.32. We further recommend that community health services for the elderly should have the following objectives -

(a) To provide and promote community-based non-institutional health care services for the elderly including the development of health maintenance and health promotion programmes with a view to preventing or deferring the need for long-term institutional care;

(b) to promote community participation, in particular the family and neighbours, in the total health care of the elderly;

(c) to co-ordinate, co-operate with and provide advice to relevant organizations involved in providing health care for the elderly; and

(d) to assist in providing training and professional support to personnel at all levels, including volunteers and care-givers,

involved in providing health care for the elderly.

Scope of Service

9.33. In terms of **health promotion**, we recommend that the CHEU of the Department of Health should adopt a more targeted approach to promoting health education among the elderly. To avoid duplication of resources, joint projects should be run with HKCSS, non-government agencies and other district organizations to provide health education for the elderly. CNS should also take part in providing individualized health education to elderly patient-clients in their home environment.

9.34. At a territory-wide level, we are aware that following the recommendation of the Central Committee on Services for the Elderly[7], an Ad Hoc Committee on Community Education on Ageing was set up in late 1989 to examine the area of community education on ageing with a view to encouraging the public to pay respect and concern to elderly persons and to educate both the young and the elderly on various aspects of ageing. The Committee comprises representatives from SWD, CHEU and HKCSS and is tasked to compile a report and make recommendations for implementation.

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[7] The Central Committee on Services for the Elderly was established on 1 July 1987 by the Secretary for Health and Welfare to review policy on services for the elderly and to monitor progress in the implementation and development of services for the elderly in Government departments and welfare agencies. It reported in September 1988 and implementation of its recommendations is underway.

9.35. We endorse the objectives of community education on ageing and feel that promotion of public awareness of ageing should be an on-going commitment. We therefore recommend that consideration should be given to the setting up of a more permanent committee to co-ordinate activities in community education on ageing and to advise on strategies, themes and targets of such activities.

9.36. To ensure wider dissemination of health education to the elderly and the community at large, we recommend that health programmes and messages through the mass media on ageing should be strengthened.

9.37. In terms of **preventive care**, we have discussed in Chapter Six the benefits of health screening in terms of early detection of illnesses. We have concluded in that context that opportunistic screening for the elderly attending GOP clinics should be conducted. To get the best value out of health screening programmes conducted by non-government organizations and "grassroots" associations from time to time as part of a health fair or festival for the elderly, we recommend that the Department of Health should develop a health screening protocol for the reference of these organizations.

9.38. As regards **curative care**, a large proportion of the elderly are making use of the GOP service. Many of them are chronic cases whose conditions are rather stable but need continuing care. Generally, priority medical consultation for the elderly is available in GOP clinics. The form of priority given varies from one clinic to another depending on the pattern of attendance as well as

operational and staff constraints. The commonest form of priority is the setting aside of a number of discs for those aged 65 and above. In addition, there are special arrangements in certain clinics for the elderly from homes or centres. We are generally satisfied with the present arrangements for the elderly patients from institutions but note that individual elderly patients may encounter difficulties in securing appointments or having to queue up for too long. Adoption of an advance appointment system for chronic cases that we have recommended in Chapter Eight would go some way towards addressing this problem. In addition, we shall recommend in Chapter Thirteen that elderly patients be regarded as one of the target groups in terms of subsidized GOP charges.

9.39. We are quite concerned about the lack of transport and/or escort service for the frail elderly to attend medical consultation. According to one health survey of the elderly in Hong Kong, some 40% of the respondents who said they had difficulties in visiting a doctor attributed these to the lack of escort or transport facilities[8]. We have considered a variety of options including the provision of an additional special traffic allowance to the elderly receiving public assistance or disability

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[8] Among the respondents interviewed in a health survey of the elderly conducted by Dr Iris Chi in 1988, 393 of the 1 172 respondents said that they had difficulties in visiting doctors. 103 of these quoted "no escort" while 56 said that they had "traffic difficulty". Source : A Health Survey of the Elderly in Hong Kong, 1989.

allowances, the extension of the Rehabus service for the disabled to the frail elderly or a wider use of the ambulance service. We have noted the problems associated with each of these proposals and feel that for the time being, support from volunteers and neighbours would be more appropriate.

9.40. As regards **rehabilitative care**, most of our recommendations on CNS would benefit the elderly. In addition, we have considered the merits of specially designed rehabilitation programmes targeted towards the health problems which the elderly most commonly encounter such as stroke rehabilitation programmes. Similar programmes are already available and the development of community rehabilitation services, as part and parcel of the primary health care system, would meet this objective.

An Integrated Approach : The Role of the Family, the Community and the Non-government Sector

9.41. Community services and rehabilitative care require an integrated approach and co-operation of the various sectors -- primary health care, hospital, social welfare, housing, transport. A variety of services run by different departments are already in existence to promote the well-being of the elderly, the disabled and the sick through care in the community and by the community. The question is one of co-ordination and integration to achieve a multi-disciplinary approach in which the various disciplines interact with a view to provide whole-person care to the client.

9.42. While in the short term, better integration could be achieved by improving liaison between the

parties concerned or setting up co-ordinating bodies or other channels of communication, we need a structure which would be conducive to the provision of an integrated service and the adoption of a team approach. Our discussions in Chapter Eleven on the concept of a district health system have been conducted partly with this objective in mind.

9.43. Given our emphasis on an integrated approach, it is appropriate for us to end this chapter with a note on the role of the family, the community and the non-government agencies.

9.44. Acceptance of greater responsibility for health by the community, families and individuals and their active participation in attaining it is an effective means to produce maximum health benefits to the greatest number of people. In almost all the services reviewed in this chapter, emphasis and attention have been placed on the participation of the patients themselves, their family members, community groups and non-government agencies. Without their support and co-operation, health workers would find themselves struggling in isolation.

9.45. There is plenty of scope for innovative approaches to mobilize the family, the community and non-government agencies to provide better health care to individuals. We have noted the positive development in the formation of self-help groups for certain common diseases such as diabetes or asthma. We look forward to more participation at the district and neighbourhood levels.

CHAPTER TEN

TRAINING OF HEALTH CARE PERSONNEL

Introduction

10.1. "Good medical education leads to, and requires, good medical care; neither is possible without the other"[1].

10.2. Health care personnel play an important role in the delivery of primary health care. The supply of well-trained health care workers is essential to the provision of quality service to the community. For this purpose, adequate facilities and opportunities must be made available for the basic training, postgraduate training and continuing education of members in the primary health care team. This team comprises doctors, nurses and other supplementary staff.

10.3. The basic objective of training is to enable health care workers to understand their roles and to perform their duties effectively and efficiently.

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[1] Foreword in the Report of the Working Party on Postgraduate Medical Education and Training, October 1988. This Working Party was chaired by Dr K E Halnan and has recommended, inter alia, the setting up of a Hong Kong Academy of Medicine to undertake and supervise postgraduate medical education, training and continuing medical education. This report is hereinafter referred to as the Halnan Report.

Training programmes can be formal and structured leading to a higher qualification, or informal aiming to provide continuing education to update professional skills and knowledge. Where possible, such training programmes should be organized locally especially in the context of primary health care which reflects the economic conditions and socio-cultural characteristics of the territory and addresses the main health problems in the community.

Training of Doctors

10.4. The range of knowledge, skills, exposure and attitudes required by a primary care doctor is very different from those required by his medical colleagues working in hospitals. In Hong Kong, primary medical care is largely provided by general practitioners[2]. In the private sector, most of the general practitioners have little or no formal

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[2] General practitioners are doctors practising the discipline of general medical practice versus specialist disciplines. A general practitioner is expected to have a grasp of the many medical disciplines involved in order to be able to deal with the broad range of physical, psychological and social problems presented by primary care and to co-ordinate the care provided to the patient by many health workers. The term "general practice" is often used interchangeably with the term "family medicine" which in North America, is defined as the medical discipline which provides primary, continuous, comprehensive and whole-person care to individuals and families in their natural (home) environment. In our Report, we have adopted the term "family medicine" to refer to the medical specialty in which doctors in primary care should be trained.

postgraduate training in family medicine before taking up their own independent private practice. In the public sector, the need for such training for doctors working in GOP clinics was not recognized until very recently[3].

10.5. In Chapter Eight, we have recommended that the GOP service should be developed on the concept of good family practice. To achieve this end, we have recommended that training of GOP doctors in family medicine should be accepted as an essential priority in the development of the GOP service. Furthermore, in order to bring about an overall improvement in primary medical care to the community, the bulk of which is provided by doctors in the private sector, we consider that opportunities for further training should be extended to private practitioners. The following section contains our discussion on training of doctors in family medicine and other disciplines related to the delivery of primary health care.

Training Doctors in Family Medicine

10.6. Family physicians are our long-term investment. Governments in other parts of the world are now funding training in family medicine because they realize that family physicians deliver the most

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[3] The Department of Health, since its inception in April 1989, has recognized the need for its staff to acquire further training especially in the field of family medicine. In co-operation with the universities, the HKCGP and HSD, it has organized a series of orientation and refresher courses for GOP doctors.

cost-effective care to the patients. This consideration will become more and more relevant as many countries are facing the problem of rapidly rising costs of financing health services.

10.7. A family physician is a registered medical doctor specializing in family medicine. He cares for individual patients and members of their families and takes the family into account in his diagnosis and management. He is the first doctor to be consulted whenever a patient is in need. He provides total care in that he emphasizes not only the physical, but also the social and psychological aspects of health. He provides comprehensive care to patients of both sexes and all ages irrespective of the type of illness and does not limit his service to only diseases of a particular group of patients or organ-system. He provides continuing care, which allows for good understanding of the needs and co-ordination of the care for the patient[4].

10.8. It has been well recognized that building up a pool of quality family physicians would result in improved health services and better use of existing specialist facilities. Hospital admissions would also be reduced and hospital-based doctors would realize that they could refer with confidence more of their patients back to the general practitioners for follow-up and continuing care.

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[4] This definition of family physician is contained in the pamphlet "What is a Family Physician?" published by the HKCGP for education of the public.

Undergraduate Teaching

10.9. The importance of family medicine should be stressed at the early stage of medical education, that is, at the undergraduate level. In this respect, the medical faculties of HKU and CUHK have undergraduate teaching programmes in general practice or family medicine. At HKU, this is administered by the General Practice Unit of the Department of Medicine; at CUHK, the Department of Community and Family Medicine provides education in family medicine for undergraduates and postgraduates. Practice training for HKU medical students is available at the clinic run by the HKU General Practice Unit at the Violet Peel Polyclinic and that for CUHK students at the clinic run by the CUHK Department of Community and Family Medicine at the Lek Yuen Health Centre.

10.10. Such programmes allow all medical graduates to have a reasonable understanding of and exposure to primary care. The emphasis in family medicine education on the health needs of the community, continuing whole-person care, interpersonal and communication skills is beneficial to all medical students irrespective of whether they pursue a career in primary health care or choose to work in hospitals or other specialties. We therefore recommend that more resources should be devoted to training in family medicine at the undergraduate level and if possible, a separate department of family medicine should be established at both universities to reflect the growing importance of this discipline.

Postgraduate Training

10.11. The Halnan Report has recommended the development of local vocational training programmes in order to achieve a high standard of health care in Hong Kong. The Report has also indicated the need for more development in vocational training in family medicine. We are pleased to note that the Hong Kong Academy of Medicine Preparatory Committee has decided that the College of General Practitioners will be one of the foundation colleges under the future Academy of Medicine. This, we believe, would greatly facilitate the development of training programmes in this specialty and the elevation of the status of family medicine in Hong Kong. Admission to the Academy is open to all practitioners, in both the public and private sectors. This will provide a good opportunity for private practitioners to undergo further training in family medicine.

10.12. Prior to the setting up of the Academy of Medicine, there is already local vocational training in family medicine for doctors to qualify as family physicians. This is organized and supervised by the HKCGP. It is a postgraduate medical training programme for registered doctors after they have obtained their basic medical qualifications. The programme requires each trainee to work in rotation under supervision in several medical specialties that are relevant to family medicine for a minimum of two years, and then in a recognized family medicine training practice for a minimum of another two years. The performance of each trainee is subject to continuous in-course assessment and there is an end-point assessment in the form of the conjoint fellowship examination of the HKCGP and the

Royal Australian College of General Practitioners. A doctor who has successfully completed the vocational training programme and passed the examination may be eligible to become a Fellow of the HKCGP (FHKCGP) and also a Fellow of the RACGP (FRACGP). The FRACGP degree is a recognized higher medical qualification in Hong Kong, Australia and the United Kingdom. The FHKCGP has recently been accepted by the Medical Council of Hong Kong as a quotable qualification, one which can be used in the title or description of a registered medical practitioner.

10.13. In addition, the Department of Community and Family Medicine of CUHK has jointly organized with the University's Department of Extramural Studies a Diploma Course in Family Medicine. This is a 40-week part-time day-release course which is basically academic in nature and is open to both GOP doctors and private practitioners.

10.14. We consider that the two medical faculties should have a greater role to play in postgraduate education and vocational training in family medicine. This would require the provision of adequate facilities for the purposes of teaching. For HKU, the General Practice Unit now at the Violet Peel Polyclinic will move into a new clinic under construction at Ap Lei Chau. This clinic has been purposely designed for teaching functions in general practice and is expected to be ready in 1991/92. The new facilities will enable the university to develop postgraduate training programmes in family medicine. For CUHK, the present teaching facilities at the Lek Yuen Health Centre are inadequate to cover postgraduate training in addition to the Diploma Course and extra space would need to be

found. We recommend that more and better clinic facilities should be made available to the universities for undertaking postgraduate education in family medicine.

In-Service Training and Continuing Medical Education

10.15. For those who are already in practice and who do not have an aptitude to undergo formal postgraduate training, short-term in-service training courses and continuing medical education would be more appropriate. In this respect, we are aware that the Department of Health has started to organize both orientation and in-service refresher courses for doctors working in GOP clinics in collaboration with HKCGP since the latter part of 1989. For doctors in private practice, we feel that HKCGP and the medical associations should continue to organize courses to update the practitioners' skills and knowledge.

Training of GOP Doctors in Family Medicine

10.16. We have placed emphasis on improving the quality of service at GOP clinics. This would be possible only with a cadre of well-trained doctors. In this respect, we are pleased to note that virtually all GOP doctors who had responded to the survey conducted by the Department of Health said that training was required for their practice in GOP clinics, with 80% of them preferring refresher courses and 65% preferring a structured programme leading to a higher qualification. A considerable proportion of doctors was in favour of both.

10.17. While we were deliberating on this subject, the Director of Health had invited Dr Wesley FABB, National Director of Family Medicine Programme, RACGP, to undertake an assignment in Hong Kong on the training programmes that would be appropriate to doctors in GOP clinics and which would improve the quality of the service. To avoid duplication of work, we are content to leave this planning task to Dr Fabb who is very knowledgeable and has extensive experience in designing training programmes for doctors in family medicine. Dr Fabb's assignment was completed in October 1990 and his major recommendations are summarized in the following paragraphs.

10.18. "On the successful completion of training, the doctor will have the knowledge, skills and attitudes required for the provision of high quality, continuing, comprehensive, co-ordinated whole-person care to individuals and families in their community setting, with particular emphasis on illness prevention and health promotion"[5]. This is the general objective for training in family medicine highlighted by Dr Fabb.

10.19. Having regard to the varied educational backgrounds and aspirations of doctors in the GOP clinics, a variety of training programmes would be necessary. Dr Fabb has recommended that four training and educational streams should be implemented. These are -

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[5] Assignment Report on Training and Educational Programmes in Family Medicine by Dr Wesley FABB, October 1990, page 67.

(a) a four-year vocational training programme in family medicine, comprising basic and advanced training, and leading to Fellowship of HKCGP/RACGP;

(b) a two-year advanced training programme in family medicine for experienced GOP doctors leading to Fellowship of HKCGP/RACGP, subject to the approval of HKCGP;

(c) a course of advanced education in family medicine; and

(d) a programme of continuing medical education.

10.20. The first stream would encompass in-service training in hospitals in a variety of disciplines for two years and another two years in a community setting -- GOP clinics and other services of the Department of Health; an accompanying education programme covering a wide range of clinical topics relevant to family medicine; quality assurance activities and research projects; and structured assessment throughout training and at the end of the programme. The second stream would include all the above components except the in-service training in hospitals. This is intended for GOP doctors who have had considerable experience in out-patient service but who do not wish to return to in-patient hospital training. The third stream would not comprise any in-service training. The fourth stream would make use of the existing continuing medical programmes provided by HKCGP and other medical associations.

10.21. Trainees of the first two streams who have satisfactorily completed training would be awarded a Certificate of Satisfactory Completion of Training. Those who succeed in the HKCGP/RACGP Conjoint Examination would be awarded the Fellowship of the two colleges, that in respect of the second stream trainees is subject to HKCGP's agreement. For participants in the Course of Advanced Education, a Certificate of Successful Completion of the Course would be given to those who reach the required standard. The certificate should contribute to career development and promotion.

10.22. Dr Fabb has also reviewed in his Report the educational resources and facilities now available for training doctors in family medicine. These include public (soon Hospital Authority) hospitals and specialist clinics, private hospitals, private practices, the medical faculties at both universities, the HKCGP, the Department of Health's GOP clinics and various public health services including MCH centres, special clinics in Tuberculosis & Chest and Social Hygiene, Port Health and Occupational Health Services. To augment these facilities, we recommend that training centres in primary health care should be set up by the Department of Health. The Ngau Tau Kok Clinic at Kwun Tong and the Yan Oi Polyclinic at Tuen Mun which we have identified for development into district health centres on a pilot basis are considered suitable for development into training centres. This is discussed further in Chapter Eleven. The expansion in facilities for the HKU General Practice Unit in the new Ap Lei Chau Clinic and expansion of the Lek Yuen Health Centre used by the Department of Community and Family Medicine of CUHK that we have recommended previously would also provide additional venues for vocational training.

10.23. To oversee the various programmes, Dr Fabb has suggested the formation of a Board of Studies in Family Medicine comprising representatives of the Department of Health, the Hospital Authority, the Academy of Medicine, the HKCGP, the universities, hospital specialists, nursing staff and community representatives where appropriate.

10.24. As 70% of medical consultations in Hong Kong are with private practitioners who require similar training in order to deliver quality care to the community, it would be desirable to extend to private doctors such opportunities for further training. We also share Dr Fabb's view that instead of perpetuating the distinction between primary care doctors in the public and private sectors by having two entirely separate training programmes, co-operation and integration should be promoted. The possibility of allowing private doctors to enrol in some of the training programmes should be considered as a means to encourage doctors in the private sector to undergo training. This, however, should be done on the basis of the private doctors paying a fee in order not to divert limited public resources in training to practitioners in the private sector.

10.25. Generally, we feel that Dr Fabb has mapped out a feasible and desirable programme for training GOP doctors in family medicine, early implementation of which would bring substantial improvements to the GOP service. In addition, we are conscious of the fact that optimal training would not be possible without an adequate supply of trainers, suitable facilities in terms of hospital and clinic environment and incentives to undergo training in the form of recognition of

qualifications in family medicine and promotion prospects for GOP doctors. The development of a better career structure for GOP doctors and training centres are discussed in Chapter Eight and Chapter Eleven respectively. To boost the supply of trainers, we recommend that suitable arrangements should be devised to seek the assistance of the medical faculties of the universities and HKCGP. The College has a strong body of members who are qualified trainers. Most of them are working in the private sector and can be dependent upon to help. With the necessary resource enhancement, both the College and the medical faculties would be able to contribute to the various educational programmes.

Training of Doctors in Other Related Disciplines

10.26. Other than family medicine, training in other specialties relevant to primary health care services should also be given adequate attention.

10.27. In the field of Community Medicine, undergraduate training is provided by the Departments of Community Medicine at the two universities. Limited postgraduate programmes are provided by the universities and in-service training is available within the Government sector. These limited local training opportunities are augmented by postgraduate training available in overseas countries like the United Kingdom, Australia, New Zealand and Singapore. With the establishment of a College of Community Medicine under the future Academy of Medicine, it is expected that more formalized training programmes in this discipline can be organized locally.

10.28. Community medicine encompasses a wide range of topics which are closely related to the health needs of the community and has relevant application in the delivery of primary health care, from health education to special services such as social hygiene, mental health and occupational medicine. Doctors specially trained in community medicine are expected to play an important role in our recommendations on the student health service, health information and health services research. We are aware that the Hong Kong Society of Community Medicine has set up its own working group to study the development of training programmes in community medicine, taking into account the views of the Hong Kong Academy of Medicine Preparatory Committee. Its ultimate objectives are to provide both academic and practical training in Hong Kong for doctors to become specialists in this field. We recommend that support should be given to the development of more local training in community medicine.

10.29. For doctors working in FHS, the Department of Health has organized attachments for them in the Obstetrics and Gynaecology Unit of HKU and plans are in hand to expand this arrangement to include attachment schemes in the Paediatrics specialty. We recommend that short-term training attachments to the relevant medical specialties for doctors involved in the delivery of primary health care should be further developed. Since doctors assume a leading role in the primary health care team, we recommend that they should also be provided with opportunities for management training to better equip themselves to co-ordinate, manage and evaluate the services for which they are responsible.

Training of Nurses

10.30. At present, all nurses undergo basic training in nursing schools attached to hospitals. This should continue to be the main source of supply of the nursing workforce in Hong Kong, although the Hong Kong Polytechnic has introduced a full-time nursing degree course in the 1990/91 academic year and another one is being planned at CUHK.

10.31. Post-basic training for nurses in the health field is provided at the Department of Health's Public Health Nursing School. This school runs a 12-month health nursing course which allows trainees to grasp the principles of primary health care services and practices, the skills in communication, health promotion and disease prevention. Upon graduation, they are deployed to work in health centres and clinics. This course has an annual intake of about 30 trainees and is often over-subscribed.

10.32. As in the case of doctors, nurses in the primary health care setting require knowledge, skills and attitudes very different from their nursing colleagues working in hospitals. The work of primary health care nurses in many countries is not confined to assisting the doctor in rendering treatment to patients. They are increasingly assuming a wide range of responsibilities including functioning as nurse practitioners in their own right. At the other end of the spectrum, they are performing the role of health educators : providing individualized health advice and counselling to patients in the clinic or home environment and referring the patients' needs to other appropriate carers or welfare service providers. While

primary health care nurses take care of people of all age groups, they are particularly involved with mothers and children and the elderly, contributing to health promotion and rehabilitative care.

10.33. Primary health care nurses play an important role in many of our recommendations on the delivery of primary health care. These include health education, health screening, the new Student Health Service, community health services for the elderly and improvements at GOP clinics.

10.34. On the other hand, we have observed that the nursing workforce at GOP clinics is currently under-used and its potential underdeveloped. Problems arise mainly in the inappropriate use of the skills of the nurses in the clinic setting. While they are still performing routine dressings and injections, the amount and content of their work have been increasingly diverted to the less nursing-oriented duties such as maintaining order in the clinics, taking temperature, answering simple queries from patients and acting as a chaperon to male doctors. To ensure the most economical utilization of nursing resources in GOP clinics, a two-pronged approach should be adopted. While the responsibilities of nurses in GOP clinics should be developed to make better use of their skills, including the introduction of health practice nurses[6], we recommend that the idea of having clinic assistants to assist fully-trained nurses in less technical work should be tested. These clinic

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[6] See footnote [18] in Chapter Eight.

assistants would require some basic training and in the course of time, could become members of the primary health care team in rendering basic health care advice or health education to patients.

10.35. Due to the limited training capacity of the Department of Health's Public Health Nursing School, a large proportion of the some 800 registered nurses within the Department have not undergone public health training. This situation is most unsatisfactory. To meet the nursing staff's aspirations for advanced training and to prepare them to take on more challenging responsibilities including those of a health practice nurse, we recommend that the training capacity of the Public Health Nursing School should be expanded as a matter of urgency. We further recommend that the Department of Health should explore with the universities and the Hong Kong Polytechnic the possibility of organizing post-basic courses in public health nursing. As in the case of doctors, the need for continuing education and refresher courses for nurses should also be emphasized. In designing the curriculum of such courses, due account should be given to our recommendations on the delivery of primary health care services.

10.36. In our discussions on CNS in Chapter Nine, we have recommended that the development of quality nursing service through training and continuing education for community nurses at all levels should be one of the objectives for the service. We have also suggested a wider scope of service for community nurses especially in providing health education and special nursing care. Enhanced training for community nurses in these respects is therefore necessary.

10.37. In view of the small number of community nurses, there is at present no separate institution or designated trainers responsible for CNS training. Basic CNS training programmes are organized annually by the nursing schools under HSD for registered nurses and enrolled nurses on an alternate basis.

10.38. The review conducted by the Working Group of the CNS Joint Consultative Committee[7] has identified several key problems regarding CNS training, particularly the inadequate training in special care areas like Continuous Ambulatory Peritoneal Dialysis (CAPD), stoma, hospice, diabetes and incontinence. This view is also shared by doctors whose opinion on CNS training was obtained through a special survey. They indicated that while training in basic nursing care was adequate, special/advance training for CNS was insufficient. To address these problems, the Joint Consultative Committee has recommended that -

(a) specialized nursing teams should be set up within CNS in special care areas like geriatric assessment, hospice care and incontinence care so as to provide expert professional advice, to enrich the basic CNS training and to provide continuing in-service training and education to community nurses;

(b) in areas where specialized services are already available, such as diabetic care and CAPD care, there should be collaboration

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[7] This review by the CNS Joint Consultative Committee is mentioned in Chapter Nine, paragraphs 9.6 to 9.11.

between CNS and other members of the nursing profession to secure professional advice and training in these areas;

(c) regular seminars or workshops to provide continuing education for community nurses should be organized by the Joint Consultative Committee; and

(d) more opportunities for the participation of community nurses, both in the government and subvented sectors, in educational programmes run by the Continuing Nursing Education Committee under the Nursing Administration within HSD should be sought.

10.39. While we support these recommendations on strengthening the training of community nurses, we consider that the long-term organization of training for community nurses should be addressed in the context of our recommendation to develop CNS as a community-based service under the Department of Health. We therefore recommend that the possibility of putting community nurse training under the auspices of the Department of Health's Public Health Nursing School should be explored.

10.40. Like their medical colleagues, it is also important for nurses in the managerial positions to undergo management training to assist them in developing the necessary skills for their role.

10.41. In the course of our deliberations, a review of the public health nursing services was carried out by two nursing experts from the United Kingdom, Miss

Heather WILLIAMS and Miss Denise DENNEHY. They were invited by the Director of Health to review the administration of the public health nursing services and to advise on the appropriate educational programmes for nurses that will meet the future public health and community needs of Hong Kong. They have made strong recommendations on the need for continuing training and education for the nursing staff. They are of the view that health nurses should become the main workforce in centres and clinics in the health sector. All enrolled and registered nurses working in the health sector should undergo the health nursing course. In addition, induction courses should be arranged for new staff and refresher courses planned for serving staff on a regular basis. There should also be opportunities for them to update their clinical knowledge so that nursing practice can be modified to meet changing health care needs. On CNS, the two nursing experts are also in favour of community nurse courses being set alongside courses for health nurses.

Training of Other Health Care Professionals

10.42. Apart from doctors, nurses and the clinic assistants that we have proposed, the primary health care team comprises other health care professionals such as occupational therapists, physiotherapists, speech therapists, pharmacists, other paramedical personnel as well as health educators or voluntary health workers. Social workers are seldom regarded as members of the primary health care team although the community support services that they are providing -- home help service, escorting to medical consultations, aids for the physically or mentally handicapped -- are essential to promoting rehabilitative care in the community setting.

10.43. At present, formal training for most of these professions are available locally and plans are in hand to upgrade some of these courses or to introduce new ones. To meet service needs, further training programmes both locally and overseas, are provided within resources available to serving staff within the Department of Health. Unlike their medical and nursing colleagues, these health care professionals working in the primary health care setting usually do not require an orientation or training vastly different from their hospital-based counterparts. We therefore have not gone into details about their special training needs. However, we consider that the role of health care professionals other than doctors and nurses in the delivery of primary health care should be further developed.

10.44. We have in Chapter Five discussed the importance of health education. We have recommended that there should be a core of medical and nursing staff who would take up health education as a career. Other intermediaries including school teachers, social workers and volunteers also have a significant role to play in health education. We recommend that consideration should be given to the introduction of formal training whether in the form of structured post-basic courses for health care personnel or part-time programmes for other intermediaries at tertiary institutions.

The Primary Health Care Team - Some Concluding Remarks

10.45. Success in developing primary health care depends on doctors, nurses and other health care professions functioning as a primary health care team

rather than experts on their own. Very often, only lip service has been paid to this teamwork approach. In reality, it requires close collaboration between individual members of the team, mutual trust and co-operation. Team members should have a good understanding of, and respect for, the skills and contribution of other members in the team to patient care. Although the primary care doctor is likely to be the leader of the primary health care team, he or she should view his or her role as more of a co-ordinator than a sole decision-maker.

10.46. To provide the necessary framework for the application of this teamwork approach, we discuss in the following chapter the idea of a District Health System.

CHAPTER ELEVEN

THE DISTRICT HEALTH SYSTEM

Introduction

11.1. In recommending measures and changes to improve the delivery of primary health care to the public, we have attached importance to the need for efficient co-ordination among the various parts of the service and all the sectors involved. To organize health services in Hong Kong on the basis of the primary health care approach advocated by WHO, we have laid down the following conditions -

(a) that there should be a close working relationship between the Hospital Authority, its Regional Advisory Committees and individual public hospitals with the Department of Health;

(b) that an effective two-way flow of information should be maintained between primary care and secondary care services whether in hospitals or specialist clinics;

(c) that there should be liaison between primary health care providers in the public sector and private practitioners;

(d) that the necessary framework should be established for the application of a teamwork approach in the delivery of primary health care;

(e) that an integrated approach should be adopted in the provision of ambulatory care and community health services involving co-operation and co-ordination with services outside the health sector;

(f) that adequate opportunities for community participation should be provided; and

(g) that health promotion and collation of health information should also be carried out at the community level.

11.2. In this chapter, we recommend a fresh approach to the organization and administration of primary health care services which will satisfy the above mentioned conditions -- the District Health System.

The Concept of a District Health System

11.3. The District Health System is a new conceptual framework for the delivery of primary health care services. Under this system, the whole territory would be divided into various geographical districts -- the Primary Health Care Districts -- and all existing clinic facilities of the Department of Health within one district would be organized into a network, through which different types of preventive, promotive, curative and rehabilitative services would be provided.

11.4. The objectives of the District Health System are as follows -

(a) **Direct responsibility for district health services** : ensuring that the district health team would be directly responsible for planning health care services which would best correlate with the needs of the population in the district;

(b) **Effective co-ordination and planning of services** : facilitating inter-sectoral co-ordination and collaboration of different types of health services, including services provided by the public, private and voluntary sectors; enabling services to be planned according to the epidemiological and demographical characteristics of the local population;

(c) **Appropriate balance of promotive, preventive, curative and rehabilitative services** : ensuring that curative services would not be considered the only or most important element in primary health care, but that preventive, promotive and rehabilitative services are also emphasized;

(d) **Efficiency and accountability** : improving cost efficiency through rationalization of services in relation to needs and accountability for decisions and actions; and

(e) **Community participation** : establishing mechanisms for individuals and groups in the community to contribute to health service planning and decision-making processes.

Organization of the District Health System

11.5. Each Primary Health Care District would be served by a network of clinics which together should provide the following primary health care services -

(a) primary medical care service including appropriate health screening programmes at GOP clinics;

(b) family health service including the proposed well-woman clinics at MCH centres;

(c) student health service[1];

(d) community nursing service;

(e) community rehabilitative service;

(f) preventive health service for the elderly;

(g) health promotion and education service;

(h) oral health service[2]; and

(i) medical social service.

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[1] The visiting health teams and regional health centres under the proposed Student Health Service would not be provided, at least during the initial stage of operation, on a district basis.

[2] The delivery of oral health service in Hong Kong is separately reviewed by the Dental Sub-Committee of MDAC. However, oral health service is part of primary health care and should come within the organization of the District Health System.

11.6. The largest clinic in the district would become the headquarters of the District Health System to be called the **District Health Centre.** The other satellite or peripheral clinics would continue to provide the various existing services or be developed to supplement identified inadequacies for that locality in order to provide a comprehensive range of primary health care services. For instance, the administrative district of Kwun Tong could be identified as a Primary Health Care District, in which the Ngau Tau Kok Clinic would become the district headquarters. The other health facilities in the district such as the Kwun Tong Jockey Club Health Centre, the Lam Tin Clinic, the Shun Lee Government Clinic, the Yau Tong Maternal and Child Health Centre and the Yung Fung Shee Memorial Centre would become satellite clinics. All services would be delivered in a co-ordinated fashion. This system should eventually replace the present regional approach in clinic administration[3].

11.7. Stationed at the District Health Centre and overseeing the day-to-day operation of the District Health System would be **a consultant in family medicine or community medicine.** A consultant status is considered essential to ensure that the officer would have sufficient knowledge, experience and status to discharge the wide scope of responsibilities under the District Health System. These include -

(a) heading the district primary health care team, members of which include all staff working in the various district clinic facilities;

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[3] Currently, clinics of the Department of Health are administered through four regions - Hong Kong, Kowloon, New Territories East & New Territories West, each headed by a Community Physician.

(b) liaising with the district hospital's medical superintendent (or Hospital Chief Executive under the Hospital Authority) and other sectors in the district; and

(c) performing a clinical role in terms of initiating research into the health needs of the community, planning local health services, providing the necessary medical support to CNS and DOT service and overseeing training needs of members of the health care team.

The creation of a consultant post in family medicine or community medicine to oversee the Primary Health Care District would also be in line with our recommendations in the preceding chapters: that the GOP service should be developed as a specialty with consultant posts in family medicine and that a better career structure should be developed for GOP doctors who have acquired the necessary postgraduate qualification and experience.

11.8. In the course of our deliberations, we have considered the alternative of developing "primary health care centres". These would be one-stop, district-based health centres with all promotive, preventive, curative and rehabilitative services centralized under one roof[4]. Implementation of this concept would require extensive capital works either in terms of redeveloping smaller clinics into primary health care

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[4] This approach is similar to the operation in Singapore, where government clinic services are delivered mostly through district-based polyclinics, replacing the older and smaller clinics or dispensaries.

centres to make room for all the services or building new ones from scratch and closing down smaller clinics. In our view, the provision of primary health care services by only **one** major health centre in each district, instead of a number of clinics as at present, would create difficulties in access, especially for the elderly. Furthermore, such a large-scale redevelopment programme would not be cost-effective in terms of utilization of resources. The medical and health services in Hong Kong have already undergone a massive expansion over the past two decades with the construction of new hospitals and clinics -- it is time to consolidate rather than to proliferate.

Formation of Committees

11.9. To facilitate co-ordination with hospitals and other community service providers and to ensure community participation, a **District Health Committee** would be set up in each Primary Health Care District. Its functions would include -

(a) liaison between the primary health care team and other service providers in the district, including district hospitals, specialist clinics, private practitioners, non-government agencies and the Social Welfare Department;

(b) providing a forum for easy exchange of information between providers of health care and representatives of the community; and

(c) enhancing the role of the community in the identification of health needs, planning of health strategies and implementation of health programmes.

11.10. The District Health Committee would comprise the consultant of that Primary Health Care District, community representatives/District Board members, the medical superintendent[5] of the district hospital, private practitioners, representatives of the Social Welfare Department and the relevant non-government agencies.

11.11. To ensure smooth operation and efficiency in the delivery of services within the district and to provide the framework for the application of a teamwork approach, the consultant of the Primary Health Care District would require the support of an internal **Management Committee** comprising doctors, nurses, administrators and other health care personnel working in the district.

11.12. To provide advice on professional matters relating to various aspects of primary health care and to address problems common to all Primary Health Care Districts, a **Professional Committee** should be set up at the headquarters level with involvement of the universities[6], the Hospital Authority, the future Hong Kong Academy of Medicine, in particular the colleges of general practice and community medicine, the medical associations, the nursing and allied professional associations and heads of the various service divisions in the Department of Health.

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[5] This would be the Hospital Chief Executive under the PHA's proposals.

[6] In particular the departments in general practice/ family medicine and community medicine.

11.13. A diagram illustrating the District Health System is at Appendix 18.

<u>The Ngau Tau Kok Clinic and the Yan Oi Polyclinic</u>

11.14. Taking into account the limited availability of resources especially in terms of trained personnel and the advantages of a gradual, step-by-step approach, we are in favour of introducing the District Health System on a pilot basis. On the advice of the Director of Health, the Ngau Tau Kok Clinic at Kwun Tong and the Yan Oi Polyclinic at Tuen Mun have been identified as suitable facilities for the testing of the various innovative ideas that we have recommended for strengthening the delivery of primary health care.

<u>Development into District Health Centres</u>

11.15. To try out the District Health System approach to the delivery of primary health care, we <u>recommend</u> the Ngau Tau Kok Clinic and the Yan Oi Polyclinic be developed into District Health Centres serving as the headquarters of the Kwun Tong and Tuen Mun Primary Health Care Districts respectively. The Ngau Tau Kok Clinic and the Yan Oi Polyclinic have been selected for this purpose because -

(a) the Kwun Tong and Tuen Mun districts have quite different demographic characteristics and the health needs of the local community will differ in the primary health care context;

(b) these districts already possess the various service components for development into a

co-ordinated network. These include a general/district hospital -- the United Christian Hospital at Kwun Tong and the Tuen Mun Hospital at Tuen Mun, out-patient health facilities, community nursing service and welfare services;

(c) the Ngau Tau Kok Clinic and the Yan Oi Polyclinic are the relatively large health facilities in these districts providing a variety of primary health care services. In both clinics there are already facilities in general out-patient, maternal and child health, family planning and community nursing services. Day care centres for geriatric and psychiatric patients managed by HSD are also housed in the Ngau Tau Kok Clinic. As regards the Yan Oi Polyclinic, these specialist services are available in the adjacent Tuen Mun Specialist Clinic. There is also a public health laboratory in the Yan Oi Polyclinic; and

(d) the development into a District Health Centre would require only minimal conversion work, but accommodation is available in these two clinics for the establishment of training centres for GOP doctors which would facilitate and complement the implementation of this new approach[7]. This is discussed in the following section.

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[7] However, training centres for GOP doctors need not be established in every District Health Centre.

Introduction of Pilot Programmes

11.16. We recommend that the various improvements to existing services which we have proposed in previous chapters should also be introduced in these two District Health Centres on a pilot basis. These include carrying out opportunistic screening for the elderly and those at-risk patients between the age of 45 and 64 attending GOP clinics, establishing a well-woman clinic as part of FHS in the MCH centres, introducing additional specialist mini-clinics on a sessional basis and re-organizing CNS as part of the primary health care team on a clinic basis.

11.17. In addition, appropriate action-oriented research projects with a view to solving some of the existing problems in the clinic service could be carried out in these two centres. Possible topics for these action-oriented research projects are -

(a) the use of health practice nurse and clinic assistant in GOP clinics;

(b) follow-up clinic and the use of management protocols for chronic patients;

(c) alternative appointment, referral and recall arrangements;

(d) patient education programmes;

(e) computerized medical records; and

(f) patient-held medical records.

Establishment of Training Centres in Primary Health Care

11.18. In Chapter Ten, we have advocated strongly promotion of postgraduate training of GOP doctors in family medicine and recommended that training centres should be set up by the Department of Health. We have recommended that such training centres should be established at the Ngau Tau Kok Clinic and the Yan Oi Polyclinic.

11.19. The full range of teaching facilities and equipment needed for a training centre in primary health care has been detailed in Dr Fabb's Assignment Report. These include a few consultation rooms, a waiting area for patients, an observation room/office for the supervisor, a seminar room for educational events and a small library. Trainees would also have access to other facilities within the Ngau Tau Kok Clinic and the Yan Oi Polyclinic. Exposure to the District Health System approach experimented in these clinics would be an additional advantage for the trainees. Although these training centres would be developed largely to provide training for GOP doctors especially at the initial stage, they could also serve as training centres for other health care personnel.

Evaluation and Further Implementation

11.20. In order to identify the strengths and weaknesses of the District Health Centres and the various innovative ideas and pilot programmes implemented, we recommend that a mechanism for the close monitoring and effective evaluation of these projects should be developed. The ambit of this body should include planning, implementation, monitoring, analysis

and documentation of the projects before commencement of the scheme and their evaluation at appropriate intervals thereafter. Such a task should best be undertaken jointly by the departments of community medicine and general practice at the two universities and the Department of Health. We are pleased to note that WHO has indicated that it would provide technical assistance if required.

11.21. Depending on the outcome of the evaluation, the concept of a District Health System could be given wider application gradually throughout the territory and the innovative approaches could be adopted in other new or existing clinic facilities. The ultimate objectives would be to have the territory divided into a number of Primary Health Care Districts each with its own network of health care services to cater for the needs of the community. As the concept of a District Health System has yet to be tested, it is premature for us to recommend at this point in time the optimum number of districts or their delineation.

Conclusion

11.22. Since the publication of the 1974 White Paper on The Further Development of Medical and Health Services in Hong Kong in which a regional approach to the administration of medical and health services was recommended, a considerable measure of decentralization has taken place. Health services are currently administered through four regions. In the view of the WHO consultants, "the role, responsibilities and functions of districts should be further explored with a view to creating an organizational unit which could draw together all health care providers, including community representatives and other sectors".

11.23. The three principles underlying our proposed District Health System approach to the organization and management of primary health care services are -

(a) devolution of further decision-making authority from the headquarters level to the district level, so that health care services could be planned, implemented and correlated with other services at the local level, based on the needs of the local community;

(b) closer links between various service providers to achieve a truly collaborative approach and optimum care for the patients; and

(c) direct community participation.

11.24. The additional merit of this approach is that it would be built on the existing health infrastructure. It would make the best use of current facilities without involving a capital-intensive programme in the expansion of health facilities.

CHAPTER TWELVE

STRUCTURE FOR THE DELIVERY OF PRIMARY HEALTH CARE

Introduction

12.1. In the preceding chapter, we have recommended a framework for the administration of primary health care services at the district level. To ensure an efficient and effective system for the overall delivery of health services, we have considered whether changes also need to be introduced to the management structure at the central level. An alternative structure for the delivery of primary health care services in Hong Kong has turned out to be the most extensively debated subject in the deliberations of the Working Party.

12.2. While structural reforms for the better management of public hospitals[1] which were actively under way throughout our assignment inevitably have an impact on some of our discussions, our approach to this subject matter has been guided by the aim to provide a framework within which primary health care can be developed to achieve its stated objectives. The systems for the delivery of public hospital services and health services in Hong Kong have different problems to be addressed and will thus call for a

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[1] These refer to preparation for the setting up of a statutory Hospital Authority, outside the Civil Service, to oversee the delivery of hospital services in all existing government and subvented hospitals.

different solution. In particular, we are aware that the overriding consideration which has led to the recommendation for an independent Hospital Authority outside the Civil Service is not equally valid in considering structural changes to the delivery of health services. This refers to the need to bring subvented and government hospitals together more clearly and fully within an integrated structure accountable to Government[2].

Desirable Features of the Preferred Structure

12.3. With the objectives and principles as set out in Chapter Four, we started by drawing up a list of desirable features of the preferred structure. In so doing, we have attached particular importance to the capability within the future structure for interaction between the public sector and private practitioners. Since some 70% of medical consultations are provided by the private sector, we feel strongly that tackling problems in the public sector alone would not be sufficient to bring about an overall improvement in the delivery of primary health care to the community.

12.4. In terms of **Government's responsibility,** the preferred structure should enable Government to continue to discharge its statutory obligation as the Health Authority in maintaining liaison with international bodies, in implementing statutory health legislation and in ensuring a high level of public health in the territory. As regards provision of

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[2] Executive Overview in the Report on the Delivery of Medical Services in Hospitals, December 1985.

primary medical care, the preferred structure should be built on the existing strengths of a dual system -- a public sector and a private sector. Whether there would continue to be a clear distinction between the two sectors in the long run, Government should continue to play a strong role in primary medical care. Some of us feel that this is necessary to take care of the needs of the vulnerable groups; others feel that a robust, resilient public sector primary medical care system would help withstand possible adverse economic and social changes in society without subjecting patients to the vagaries of the marketplace; others consider that Government should take the lead in making arrangements which would facilitate collaboration between the public and private sectors with a view to raising standards of practice in both.

12.5. Primary health care requires maximum community participation in the planning, organization and operation of health care services. Despite a continued strong Government presence in primary health care, we consider it important to allow scope for **community participation** at the decision-making level of the future structure.

12.6. The preferred structure should avoid further fragmentation in the organization of medical and health services. It should ensure **efficient co-ordination** with other providers of medical and health services, in particular the Hospital Authority.

12.7. In terms of **funding**, there should be sufficient autonomy for the preferred structure to be able to plan its own budget having regard to needs and requirements. However, this would still be subject to

overall Government control as a major component of its budget will continue to come from Government. It would also be desirable for the future structure to be able to retain some or all of the income from additional revenue generated from a revised fee structure or other new initiatives so as to guarantee that fee increases are ploughed back into improvement to primary health care services. In this latter respect, most of us feel that the current financing arrangements in which all fee income is transferred to the General Revenue Account and applications for funding of new or improved services are considered separately have hampered the introduction of essential or desirable improvements, even if these could be financed through savings or additional sources of revenue generated from within the health programme.

12.8. In terms of **staffing**, we do not consider that there are sufficient justifications for a staff structure outside the Civil Service. The primary health care sector is not experiencing the problem in the hospital services where the co-existence of a Civil Service sector and a large subvented sector, each with its own terms and conditions of employment, has hindered the development of integrated hospital services. However, the preferred structure should have autonomy in employing some staff outside the normal confines of the Civil Service Regulations, especially to meet special needs. For example, it may be necessary to employ health care specialists on a part-time or sessional basis to provide service or training.

12.9. A fundamental need in any structural reform is to ensure that primary health care would be

developed with its **distinct identity.** We have noted that many of the reforms that the Director of Health has introduced since the setting up of the Department of Health in April 1989 and those that are in the pipeline had not been introduced in the past because attention, resources and emphasis were given to hospitals under the former Medical and Health Department. Finally, the preferred structure should be capable of being developed on an **evolutionary** basis.

The Options

12.10. We have considered in detail the following options which would to a varying extent meet the desirable features of the preferred structure -

Option I : The current structure, with the Department of Health strengthened to improve the service to the public and with an element of public participation through an advisory committee with medical and lay membership.

Option II : An independent statutory Primary Health Care Authority with a strengthened Department of Health within the Civil Service as its executive arm.

Option III : An independent Primary Health Care Authority outside the Civil Service along the lines of the Hospital Authority and a separate government Department of Health taking charge of public health matters. A modification of this option is for the Authority to

encompass both primary care and public health functions without a Department of Health.

Option IV : A "supra" independent Health Authority embracing a hospital division (the Hospital Authority) and a primary health care division inclusive of public health.

The following two further options have been put forward on the grounds that since the GOP service is the major problem area in the delivery of primary health care services in Hong Kong, the organization of this service should be the main focus of the future structure.

Option V : Complete privatization of the GOP service with arrangements for the continued provision of subsidized out-patient medical treatment to needy groups. Public health matters would be taken care of by a government Department of Health.

Option VI : All GOP clinics providing primary medical care to be placed under the Hospital Authority with the government Department of Health providing only preventive and promotive activities as in Option V.

12.11. Considerable thought and discussion was given to all the options. Arguments for and against each of these are set out in the following paragraphs.

Option I : A strengthened Department of Health

Arguments For

(a) There are merits in building onto the existing system. The problems in primary health care are not as great or complex as those of the hospital services and relate primarily to the GOP service. It may not be justified to revamp the overall structure for a part of the Department of Health's function, though this is an important area. Improvements could be brought about by management reforms, enhanced training, better use of resources and better interaction between the public and private sectors without setting up a new structure.

(b) Many public health activities are the direct responsibility of the government and should best be undertaken by a health authority within the government machinery where there would be more efficient co-ordination with other government departments. These activities include control of epidemics, liaison with WHO and other international health authorities, implementation of statutory functions both locally and internationally.

(c) In view of the public concern and staff problems that have been associated with the establishment of the Hospital Authority and the importance attached to health services by the community, gradual and evolutionary

changes, which would be the case under this option, are politically more acceptable than radical changes.

(d) A government Department of Health is in a position to ensure even distribution and adequate coverage of health services such as in the case of remote areas and outlying islands and to achieve uniformity of standard in the service.

Arguments Against

(a) The degree of community participation in formulating policies would be more limited in a government department than in an independent Authority; certainly public perception is such. In this respect, it was argued in the Report on the Delivery of Medical Services in Hospitals that one of the benefits that would accrue from having an independent Hospital Authority was to ensure openness to public scrutiny through membership on the Authority and its Regional Hospital Boards.

(b) In terms of the mode of delivery of clinic services, this Working Party is in favour of a multi-mode approach involving collaboration with private practitioners or promotion of private primary medical care insurance to be run by a non-profit-making organization. In both modes of operation, there would be a need for flexibility within the future structure to enter into contractual arrangements with the private sector.

(c) It is difficult to expect the current structure to be flexible enough in terms of staffing and funding to accommodate some of the desirable features of the future structure.

(d) Even if the desired flexibility could be made available within the government structure, a bureaucracy by its nature tends to suffer from a degree of inertia, rigidity and is often slow in adapting to changing circumstances. This would not be conducive to a situation which requires testing of innovative ideas, evaluation and prompt implementation. The driving force should therefore come from outside the government structure.

<u>Option II</u> : <u>An independent statutory Primary Health Care Authority with a strengthened Department of Health within the Civil Service as its executive arm</u>

<u>Arguments For</u>

(a) This resembles the Housing Authority/Housing Department structure and that in respect of the two Municipal Councils. This structure would provide the framework for the development of a more flexible approach in terms of staffing and funding - although we realize that unlike the Housing Authority or the Municipal Councils, a large part of the funding of the PHC Authority would continue to come from General Revenue and there may be less scope for funding flexibility than with these organizations.

(b) The Authority would be responsible for devising policies and giving directions to the Department of Health although such policies would have to be in line with the Government's overall health objectives and the Authority would be accountable to Government. This allows for community participation in a more direct and accountable manner than a mere advisory body to Government. In this connection, we should point out that some of us are wary of the limitations of an advisory committee set-up as in the case of the MDAC.

(c) An Authority structure would be in a better position to interact with the private sector. This would be particularly important having regard to our recommended multi-mode approach in the delivery of clinic services which involves contracting with private practitioners.

(d) By retaining the government Department of Health as the executive arm of the Authority, the public health responsibilities would continue to be discharged by a body within the government machinery and the necessary co-ordination with other government departments and international health authorities on a government-to-government basis would be preserved.

Arguments Against

(a) Although this option is less radical than the proposal to have an Authority detached from

the Civil Service (under Options III and IV), it nevertheless represents a significant structural change which requires legislative action and organizational adjustments. These changes may not be warranted in the case of primary health care which has less organizational problems than public hospital services.

(b) An Authority with a Civil Service department in the health sector whereas the Hospital Authority is outside the Civil Service may give rise to some invidious comparisons and staff management problems.

Option III : An independent Primary Health Care Authority outside the Civil Service along the lines of the Hospital Authority

Arguments For

(a) It would enjoy benefits similar to those accruing from having a Hospital Authority outside the Civil Service, such as better staff control by having the power to "hire and fire" staff and to devise terms and conditions more appropriate for health staff, a more flexible approach to develop appropriate relationships with other sectors including private practitioners, greater community participation and openness to public scrutiny.

(b) This would put primary health care services on a par with hospital services and ensure

that both would be treated with equal importance. This would help to redress the imbalance as reflected in our past and present hospital-oriented medical and health programme.

Arguments Against

(a) The creation of yet another independent Authority detached from the Civil Service could be perceived, though quite mistakenly, by the public as a further step by which Government was divesting itself of important social responsibilities.

(b) The absence of an official health authority would make it difficult for Government to discharge its proper responsibilities for safeguarding public health and other statutory functions. The option of creating a PHC Authority but retaining a government Department of Health to look after public health matters is not viable in view of the need for a sound infrastructure for the Department of Health to discharge its public health functions. In addition, this arrangement would give rise to further fragmentation in the delivery of medical and health services which would make co-ordination extremely cumbersome.

(c) The transfer of staff in the Department of Health to an independent authority would require extensive staff consultation and negotiation. Preparation for the setting up

of the Authority and the related staff disputes could delay introduction of the much needed improvement to the GOP clinics and other health services.

(d) Unlike hospital services in which the existence of a significant subvented sector called for the establishment of a statutory body independent of the Civil Service to achieve integration and better use of resources across the public sector, similar considerations are not applicable in primary health care services.

Option IV : A "supra" Health Authority responsible for both hospital and primary health care services

Arguments For

(a) This option, which envisages putting primary health care and hospital services under an Authority outside the Civil Service, would have the advantages similar to those under Option III. In addition, it would allow for integration and better co-ordination between primary health care and hospital services. It would also enable transfer of staff for training and service needs.

(b) Provision of identical terms and conditions to staff in primary and secondary care would help to solve recruitment and retention problems in primary care which are likely to arise upon the establishment of the Hospital Authority.

Arguments Against

(a) This option would have the same disadvantages as those under Option III. In addition, it may be difficult to implement this option successfully for some years to come, as the Hospital Authority will be fully engaged during its initial years with integrating the government and subvented hospitals and implementing the much needed hospital reforms.

Option V : Complete privatization of GOP service with a government Department of Health administering public health matters

Arguments For

(a) Government would not need to fund or staff GOP clinics. The financial resources could be re-allocated to provide subsidized primary medical care service to members of the needy groups for whom Government has an obligation to ensure that they have continued access to primary medical care treatment. These patients would obtain treatment from private doctors and the Government subsidy could take the form of a capitation grant to doctors for covering these patients, an allowance to the eligible recipients, a voucher scheme or reimbursement on a fee-for-service basis. The private sector is already providing some 70% of the medical consultations and should have little problem in absorbing the 15% from the public sector. There would then be one unified system of primary medical care.

Arguments Against

(a) The quality of service provided by private practitioners in Hong Kong is variable and it might not be desirable to entrust resources for the care of the needy such as the elderly patients entirely to the private sector. There would need to be an expensive monitoring system to ensure that quality service is provided and that unnecessary consultations are not being offered or demanded.

(b) The use of vouchers for treatment of members of the needy groups such as the elderly would either provide Government with an extremely large bill if the take-up rate among the eligible groups was high or incur heavy administrative costs if the eligible groups were to be further restricted through some form of means-testing. The extent of subsidy and administrative measures to restrict the size of the eligible groups would become political rallying points divorced from the health needs of the people.

(c) The public health functions of the Department of Health such as to control and maintain surveillance over communicable diseases would be difficult, if not impossible, to perform without a network of clinics under its control.

(d) Standards of good practice in primary care would be difficult to raise if the private

sector were to be left entirely on its own. The model-setting value of the GOP clinics and the impetus to improve training for doctors in family medicine would be totally lost if the GOP service were to be completely privatized.

Option VI : All GOP clinics to be transferred to the Hospital Authority with a government Department of Health administering public health matters

Arguments For

(a) There would be greater continuity of care for users of GOP clinics if the GOP service and the hospital service fall under one organization.

(b) The independent structure and set-up of the Hospital Authority would provide the flexibility needed for reforms to primary medical care at the GOP clinics as envisaged under Option II but without the need to create another Authority.

(c) Rotational training of doctors and nurses in hospitals and primary care would be easier if they work under the same Authority.

Arguments Against

(a) Primary medical care is an integral part of primary health care which is advocated by WHO and other countries throughout the world as the most cost-effective means to achieve the objective of 'Health for All by the Year

2000'. It would be a retrograde step to divorce primary medical care from primary health care and to place it under the hospital system.

(b) It is likely, as in past practice, that the greater demands of the hospitals for resources would gain priority over primary medical care. Only if the two -- hospitals and primary care -- had independent say in the distribution of resources, say, under one "supra" Authority under Option IV, could this problem be overcome.

(c) As in the case of Option V, the public health function of the Department of Health would be difficult, if not impossible, to perform without a network of clinics under its control.

(d) It may require some years to implement this option successfully as the Hospital Authority will be fully engaged in integrating government and subvented hospitals and implementing the much needed hospital management reforms during its initial years.

<u>**The Recommended Option: a Primary Health Care Authority**</u>

12.12. The various options have been debated extensively taking into account not only the desirable features of the preferred structure, but also the political and practical considerations. For instance, most of us would opt for a "supra" Health Authority under Option IV encompassing a hospital division and a

primary health care division were it not for the traditional neglect of primary health care and the advance preparation in the setting up of the Hospital Authority. In principle, we do not disagree with the comment of PHA that "a case could be made for integrating all aspects of primary health care with hospital services because with effective management and administration primary health care services can contribute to promoting and maintaining the overall health of the population, thereby reducing the need for hospital services"[3]. One way of integration, as mentioned by PHA, would be to bring primary health care and hospital services under a single umbrella.

12.13. In our opinion, such a proposition would be acceptable **only** if primary health care and hospital services are given equal status within the umbrella organization which would allow for **separate** development of both services, that is, under Option IV[4]. The suggestion to simply put all aspects of primary health care under the Hospital Authority would be difficult to implement with success given the different approaches and orientation that are required as succinctly pointed out by Dr Wesley FABB. "The mind set of the doctors and nurses in the two settings [hospital care and primary health care], and in turn the administrators, is necessarily different. In primary health care the mind set is towards the whole

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[3] From Report of the Provisional Hospital Authority, December 1989, page 130.

[4] The idea of a "supra" Health Authority integrating primary health and hospital services is further discussed in Chapter Fifteen.

person in the family and community environment, towards continuity and comprehensiveness of care, towards health promotion and preventive care as well as curative care and rehabilitation, towards low technology and low cost care, towards health education, self reliance and self care. Hospital care is the opposite in almost every way. It is focussed on organs and systems, is episodic and therefore discontinuous, almost wholly curative, high technology and high cost."[5]

12.14. Having considered the pros and cons set out in the preceding paragraphs, we conclude that Option II is the preferred structure which best displays the desirable features in the future delivery of primary health care. These include -

(a) adequate opportunities for community participation in the development of policies;

(b) sufficient flexibility for pioneering different schemes which may involve collaboration with the private sector in the delivery of service;

(c) some degree of financial autonomy to enable control over its own budget within established objectives and guidelines and retention of certain income from fees for improvement to other health services; and

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[5] From Assignment Report on Training and Educational Programmes in Family Medicine by Dr Wesley FABB, October 1990, pages 50-51.

(d) capability to interact with the non-government sector in gradually establishing a framework for the delivery of quality care to the whole community.

12.15. We therefore recommend the establishment of a statutory Primary Health Care Authority, with some degree of financial autonomy and with the Department of Health as its executive arm, to oversee the delivery of primary health care in Hong Kong.

12.16. However, we would be doing a disservice to the people of Hong Kong if we were to recommend that everything should stay put until the Authority is in place, the preparation of which will take some time. Some of our primary health care services require urgent improvement and remedy and these should be implemented without further delay. To facilitate early improvement and to pave the way for the setting up of the Authority, we recommend that immediate action should be taken to re-organize and strengthen the Department of Health. This is discussed in the following section.

Re-organization of the Department of Health

12.17. To facilitate early improvement to primary health care and to provide strong executive support for the Primary Health Care Authority upon its formation, we consider that immediate action should be taken to re-organize the Department of Health. The aim should be to reflect, in the Department's organizational structure, the importance Government attaches to primary health care and to ensure better efficiency in its operations. Our proposals in this respect have taken into account the working experience of the

Department of Health since its establishment on 1 April 1989 and the needs arising from our recommended improvements to the various primary health care services.

Present Position

12.18. We consider the existing organizational structure of the Department of Health, at Appendix 19, to be unclear in its division of services and not conducive to allowing important service areas to have direct involvement in the decision-making process. Many of the important services do not have a distinct identity of their own and this may hamper the planning of these services to respond to changing needs. The proposed revised structure is to rectify the situation and to strengthen the organization of the Department to take on new responsibilities.

Proposed Structure

12.19. The proposed organizational structure as shown in Appendix 20 would -

(a) give primary health care a distinct identity and makes for a better co-ordinated and integrated development of promotive, preventive, curative and rehabilitative services;

(b) permit better recognition, co-ordination and deployment of resources by re-grouping the activities of the Department of Health into the following five main areas :

Primary Health Services which embrace promotive, preventive, curative and rehabilitative personal health services to individuals from birth to old age;

Public Health Services which cover all specialist health services like occupational health, port health, control of tuberculosis, social hygiene and narcotics;

Development and Planning which includes service and manpower development, epidemiology studies, research and health administration;

Administration to oversee finance, supplies, auditing, personnel management, staff and public relations; and

Dental Services which require a separate division for its efficient management in view of the need for different professional staff, the size and variety of grades and the need for development in respect of oral health education; and

(c) incorporate those new service units recommended in respect of health education, student health service, health information, epidemiological research and community nursing service.

12.20. The new organizational structure is preferred on the grounds of more efficient delivery of service. We consider that appropriate ranking for the various

positions such as heads of divisions and units in the re-organized structure should be a matter for consideration by the Administration, taking into account the respective proportion of administrative and professional inputs required and the relativity of the scope of responsibilities.

Conclusion

12.21. We are fully aware that re-designing the structure for the delivery of services **alone** will not ensure quality of care to the community or resolve the problems faced by the GOP clinics or the School Medical Service. However, we need an environment which would facilitate and encourage change, and ensure that such changes have the support of not only the health authorities and health care professionals, but also the community at large. In the case of primary health care, a management structure which is capable of responding promptly and positively to changing needs and aspirations of the community is particularly important. No arrangement could achieve this purpose better than opportunities for direct community participation at various levels of the organization of health care services. The Primary Health Care Authority at the central level and the District Health System at the district level are proposed, inter alia, to meet this objective.

CHAPTER THIRTEEN

FUNDING AND IMPLEMENTATION

Introduction

13.1. We are specifically required by the terms of reference to assess the resource implications of our recommendations. This chapter presents the best available estimate of the additional financial and manpower resources required together with our discussions on fees and charges and the programme of implementation.

Funding and Manpower Requirements

Recurrent Expenditure

13.2. The tangible full cost[1] of implementing all our recommendations, except those listed in paragraph 13.7 below on which no costing can be made at this stage, is estimated to be $186.8 million per year at 1990-91 prices. As some of our recommendations, for example, introduction of the new Student Health Service or development of medical records in all GOP clinics, would be implemented in phases owing to manpower and other practical constraints, this total additional

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[1] Full cost represents the all-embracive cost in public expenditure including not only the actual staff salaries but also staff oncost such as pension, housing and other allowances as well as administrative overheads.

expenditure of $186.8 million is expected to be the annually recurrent full cost at the end of the first five years of implementation.

13.3. The major components of the additional expenditure required are as follows -

		$ Million
(a)	Enhancement to health education activities including training of health education staff and intermediaries (paragraphs 5.3 - 5.16)	6.9
(b)	Establishment of a Health Information System (paragraphs 5.51 - 5.61)	14.5
(c)	Improvements to services for children aged 0 to 5 at MCH centres (paragraphs 5.28 - 5.29)	1.3
(d)	Introduction of the new Student Health Service including school-based programmes for all primary and secondary students and operation of two regional health centres (paragraphs 7.38 - 7.54)	70.4
(e)	Conduct of a review of the occupational health service (paragraphs 5.43 - 5.47)	0.1
(f)	Expansion of the training capacity of the Public Health Nursing School (paragraph 10.30 - 10.35)	2.5
(g)	Improvements to existing GOP service including development	20.2

of medical records and introduction of drug labelling in all GOP clinics[2]

(paragraph 8.32 - 8.48)

(h)	Development of training centres in primary health care (including education resource centres) at the Ngau Tau Kok Clinic and the Yan Oi Polyclinic (paragraphs 10.16 - 10.23 and 11.18 - 11.19)	48.1
(i)	Introduction of the District Health System at the Ngau Tau Kok Clinic and the Yan Oi Polyclinic including the organization of CNS on a district basis (paragraphs 11.3 - 11.15 and 9.4 - 9.11)	4.2
(j)	Introduction of new opportunistic screening services for the elderly and at-risk groups attending GOP clinics and well-woman clinic at MCH centres on a pilot basis (paragraphs 6.8 - 6.11 and 6.17 - 6.20)	18.6
		$186.8 million

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[2] Other measures to improve the service would not require significant additional resources but could be implemented through changes in management of the clinic service or attitudes of the service providers. These include developing management protocols for patients with chronic illnesses, improving the appointment system, strengthening co-ordination between GOP clinics and specialist clinics and adopting a teamwork approach in GOP service.

Capital Expenditure

13.4. Our recommended improvements to the delivery of primary health care build on the existing health infrastructure. The only major capital works involved are the establishment of two regional health centres for the new Student Health Service and two training centres in primary health care. Both would be developed from vacant premises in existing clinics or spare accommodation which is likely to be made available in the near future[3]. Those required for the training centres have already been identified by the Director of Health at the Ngau Tau Kok Clinic, the Yan Oi Polyclinic and the adjacent Tuen Mun Clinic.

13.5. The full capital cost would be about $17.7 million at 1990-91 prices, made up of $10 million for the regional health centres and $7.7 million for the training centres.

Manpower Requirements

13.6. To implement all the proposals would require some 550 additional staff of various grades at various levels. About half of them belong to the medical (81), nursing (145) and dispenser (64) grades.

Exclusions

13.7. It must however be noted that, for practical reasons, no cost estimates have been made on :

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[3] Such accommodation within existing clinics can be released upon the closure of maternity homes.

(a) the longer-term implementation of some recommendations, especially for setting up further District Health Centres for Primary Health Care Districts, which would depend on the success of the pilot scheme involving the Ngau Tau Kok Clinic and the Yan Oi Polyclinic;

(b) the cost of setting up an independent statutory Primary Health Care Authority. However, since the Department of Health would continue to be the Authority's executive arm, the costs arising from this proposal would be confined to providing the secretariat support;

(c) collaboration with the private sector. As a principle, such forms of collaboration should involve no extra public spending. For example, in the proposed scheme involving contracting out a public clinic to private practitioners, public spending should not be greater than the cost to Government for providing the services itself;

(d) alternative provision of medical consultations to civil servants and their dependants;

(e) improvements to the career prospects for GOP doctors other than the creation of a consultant post to head the two District Health Centres and trainer posts at Consultant/ Principal Medical Officer levels;

(f) resource implications of the work of the future Academy of Medicine in respect of postgraduate training and continuing medical education in primary health care; and

(g) resources required to re-organize the administrative structure of the Department of Health which would depend on the additional number of management staff required, if any, and the appropriate ranking of such personnel.

13.8. On the other hand, the estimated $186.8 million additional recurrent expenditure would be met partly by existing resources redeployed from the School Medical Service, the further closure of severely under-utilized maternity homes and any other options for achieving better value for money which the Director of Health may introduce in the course of examining the management of certain services. It has also not taken into account additional revenue likely to accrue from our recommendations on fees and charges as discussed in the following section.

Fees and Charges

The Present Policy

13.9. Medical and health services are very heavily subsidized by public funds. In respect of primary health care services, many are provided free. These include attendances at MCH centres, tuberculosis and chest clinics and social hygiene clinics. The charge for consultation at GOP clinics is $18 inclusive of

drugs and the necessary investigations, while that for consultation at specialist out-patient clinics including the child assessment centres is $28. Community nursing service is charged $27 per visit and the charge for injections and dressings at GOP clinics is $7. Attendances at family planning clinics are charged a nominal fee of $1. These fees may be wholly or partly waived in cases of hardship on the recommendation of medical social workers.

13.10. We are aware that the present charging policy has taken into account the following principles -

(a) that it is Government's responsibility to safeguard and promote the general health of the community as a whole;

(b) that it is Government's policy that no one should be prevented, through lack of means, from obtaining adequate medical treatment; and

(c) that while public sector medical and health services should remain heavily subsidized, individuals using the services should make some contribution towards the cost.

Our Recommended Strategy

13.11. Given the role of Government in the development of primary health care in Hong Kong which we have recommended in Chapter Four[4], it is

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[4] See paragraph 4.7 in Chapter Four.

considered appropriate that the level of fees should be set taking into account the above fundamental principles. Basic preventive care services aiming to safeguard and promote public health should continue to be provided free or virtually free for all. In the case of primary medical care providing curative treatment, we feel that the principle of individual contribution should be applied more critically having regard to the individual's actual needs and ability to pay.

Promotive and Preventive Care Services

13.12. We recommend that preventive care services including immunization, maternal and child care, family planning, student health and other services conducive to the control of communicable diseases should continue to be provided free of charge[5]. This is despite the general feedback from respondents in the HKU MCH Survey that it would be acceptable to levy a per visit fee of $20 or less[6].

13.13. The new screening services that we have proposed in Chapter Six are also contributing to promotion of health and prevention of diseases. However, as we have argued therein, we do not consider that such screening services should be made free for all. We recommend that health screening services for

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[5] The validity of charging the nominal fee of $1 per visit at the family planning clinics should be examined.

[6] For details, see Summary of Surveys at Appendix 3.

the elderly and at-risk groups aged 45 to 64 attending GOP clinics and women attending well-woman clinic at MCH centres should be provided at a charge to recover the cost of investigation, with reduced charges offered to those target groups identified for subsidized primary medical care at GOP clinics. For those who cannot afford to pay, the present arrangement for charges to be waived should apply.

Primary Medical Care - Charges at GOP Clinics

13.14. Given that only 15% of all medical consultations of the general population are provided at GOP clinics, improvements in the public sector primary medical care as we have recommended in Chapter Eight would inevitably generate increased demand for the service. The single most important factor accounting for the patronage of GOP service is its low charge - $18 as compared with a fee ranging from $80 to $200 in the private sector, particularly when the amount of medicines provided is taken into consideration. Unless the "charges" and "demand" issues are adequately addressed, improvements to the GOP service would generate further demand which could in turn overload the system. It could also divert patients from the private sector to the public sector and further the role of Government as the provider of primary medical care, which is not consistent with our recommended objectives in primary health care.

13.15. In theory, demand for GOP service could be regulated by one or more of the following measures -

(a) restricting supply of service by resorting to a quota system i.e. the present arrangement

of first-come-first-served or some other allocation criteria or by actually closing down smaller clinics as in Singapore;

(b) reducing the scope of service;

(c) increasing charges at GOP clinics to reduce the gap between the public and private sectors; and

(d) changing utilization behaviour through public education, health promotion and provision of medical information to patients so that unnecessary consultations could be minimized.

13.16. We consider measures (a) and (b) politically and professionally unacceptable in view of the present discontent with the GOP service. Proposal (d) is the longer-range solution but it is not capable of producing results within a reasonably short period. The proposal under (c) to raise charges would inevitably evoke some adverse public reaction. In any event, it should be adopted with care having regard to the fact that on average current users of the GOP service tend to be the elderly and less well-off of our general population. We recognize that there are vulnerable groups in the community, particularly those who have little or no earning capacity, for whom a proposal to raise charges would reduce their ability to obtain care. We therefore <u>recommend</u> a charging policy, which identifies target groups for subsidized service at GOP clinics, in keeping with Government's policy that no one should be prevented, through lack of means, from obtaining adequate medical treatment.

13.17. In arriving at this recommendation, we have rejected the suggestion that usage of GOP service should be confined to members of the target groups. We feel that such a system would lead to GOP clinics being regarded or at least perceived by the public as second-class facilities for the poor and the indigents. This would not be conducive to meeting the objectives we set for the Government primary medical care service -- to provide quality primary medical care which is readily accessible and affordable, with special attention for certain target groups, and which will act as a benchmark for the delivery of service in Hong Kong[7]. We consider it highly desirable that all in our community should continue to have the **choice** of using either GOP service or other modes of primary medical care. Those who choose Government services and can afford to pay should not continue to be heavily subsidized. Those who cannot afford to pay should not be deprived of service through lack of means and should continue to receive care on public subsidy.

13.18. In addition, we consider a "**target group**" approach to be more efficient administratively and more acceptable politically than a "**means-testing**" approach for individual clients. Means-tests should be avoided wherever possible unless there were overwhelming public financial considerations or great potential of abuse if such tests were not in place. Having considered the present utilization of GOP service and Government's policy for subsidizing health and medical services, we

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[7] See paragraphs 8.33 and 8.34 in Chapter Eight.

do not consider a means-test approach appropriate. However, for certain people who fall outside the target groups but have genuine difficulties in affording the GOP charges, fee-waiving should still be necessary.

13.19. We recommend that the following groups should be target groups for subsidized primary medical care -

(a) **Young children aged 0 to 15 and full-time students up to the age of 18 :** the 1989 General Household Survey on doctor consultations showed that frequency of consultation among young children (aged 0 to 5) is very high. Such utilization was also borne out by the HKU GOP Survey. This may pose a considerable burden on parents. In addition, school children from Primary One to Secondary Three (aged 6 to 15) currently have the option of joining the SMS which provides economical medical treatment[8]. We have in Chapter Seven proposed that the SMS be replaced by a Student Health Service which would provide preventive and promotive care while students are expected to receive curative treatment for common ailments from GOP clinics or private practitioners. In order to give parents an economical alternative to primary medical care by private

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[8] At an enrolment fee of $15 per year and a $12 per visit charge, they are able to obtain unlimited medical consultations from a doctor of their choice participating in the SMS throughout the year.

practitioners, we propose that children aged 0 to 15 should be eligible for GOP service at **half fee.** The proposed subsidy should also extend to those in full-time studies up to the age of 18 on the grounds that they are not economically independent;

(b) **The elderly, i.e. those aged 65 and above :** we consider that the elderly should be eligible for subsidized medical care because they require greater medical attention at a time when their income is likely to be declining. As Hong Kong does not have a universal retirement benefit scheme, we consider the Government to have the responsibility for the health needs of the elderly. We propose that elderly citizens aged 65 and above should be eligible for GOP service at **half fee.** We have considered whether this age limit should be lowered to 60 but feel that this should be tied to the age limit for Old Age Allowance which is currently 66 and will be 65 from 1 April 1991;

(c) **People on disability allowances :** we are aware that recipients of these allowances are not means-tested and this group may include those who have reasonable earning capacity and can well afford the GOP charges. However, in view of the small size of this group, we propose that all recipients of disability allowances should be eligible for **half fee;** and

(d) **People on public assistance** : by definition, this group has financial difficulties and rely on social security for their livelihood. Many of them already have their medical charges waived under the current arrangements. We propose that this group should be eligible for the service **free of charge.** Regarding people with an income just above the public assistance level who may not be able to afford GOP charges, we propose that they continue to be eligible for fee waiving. One possibility would be to provide them with subsidized service at no charge or half fee on a simple income declaration as in the case of eligibility for Old Age Allowance for those currently aged 66 to 69.

13.20. We have considered very carefully whether primary medical care for the chronically ill should be subsidized. One argument in favour of extending subsidies to these people is to ensure that they would not be inhibited from seeking continuous medical treatment. We do not propose to include the chronically ill as a target group on the grounds that those who are chronically ill <u>and</u> old or less well-off would already be covered by our proposed target groups and that with the improved management of chronic patients at GOP clinics, the frequency of their attendance would be reduced. Again, in cases of hardship where the frequency of attendance is high and the disposable income for seeking medical attention is low, due arrangement for fee waiving would be available.

13.21. Our proposed target group approach is administratively simple to operate, being easily verifiable in respect of the young and the elderly by reference to identity cards and in respect of public assistance or disability allowance cases, by public assistance recipient cards or disability registration numbers or some other arrangements to be worked out by the Department of Health and SWD.

13.22. In setting the level of fees at GOP clinics, we recommend that the following two principles should apply -

(a) non-target group patients should not be charged above cost in order that the fees collected could go to subsidizing the target groups. Subsidy for the needy should remain Government's responsibility; and

(b) charging non-target group patients at cost should be the eventual aim. This should be achieved gradually with visible improvements in the quality of service.

13.23. The objects of our proposed target group approach for charging at GOP clinics are to regulate the demand for public sector primary medical care more rationally, to spread the cost of medical care more equitably over the community and to release public funds for other improvements to health services. This approach also conforms to the principle of individual contribution where affordable.

13.24. The respective sizes of the target-group and non-target-group patients among current GOP users will determine how successful a target group approach would be in meeting the desired objectives. On the basis of findings of the HKU GOP survey and the Department of Health's records, it is estimated that slightly less than half (46%) of the current GOP users are members of the target groups[9]. Assuming that the present GOP charges were to be doubled, that is, from $18 to $36, the young, the elderly and the disabled would continue to pay $18 while those on public assistance would receive the service free. However, overall subsidy from the public purse to the GOP service would be reduced, thereby releasing some public funds for other purposes. We should, however, emphasize that the resources so released should be used for improvements to other health care services instead of being returned to General Revenue.

Community Rehabilitative Service

13.25. The majority of users of existing community rehabilitative services are the elderly and the disabled. The fees for these services are at present set at a highly subsidized level. Since these services are provided to distinct target groups and access to them requires some form of prior medical assessment (unlike usage of GOP service which is patient-initiated), we do not see particular grounds for deviating from the present charging policy. We recommend that fees for community rehabilitative services should continue to be set at a highly subsidized level.

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[9] For details, see Appendix 21.

13.26. For CNS, the per visit charge is set at 80% of the daily in-patient charge for public beds in general hospitals. This is currently $27 while the overall average cost to public purse is $138 per home visit[10]. The same rate is applied to all clients but full or partial remission is available on the recommendation of medical social workers or other designated officers authorized to waive fees. We feel that the 80% level is arbitrary and in the light of our recommendation to develop CNS on a community basis, it would no longer be appropriate to link CNS fees to in-patient charges in hospitals. In order to properly reflect the cost and subsidy provided to users of this service, we recommend that :-

(a) the charge should be calculated and expressed as a percentage of the cost of the service and be regularly updated on this basis;

(b) the charge should continue to be set at a substantially subsidized rate so as not to deter the use of the service which contributes to keeping patients out of hospitals and promoting ambulatory care; and

(c) the charge should continue to be set at a flat rate for all with the existing mechanism for waiving of fees but the possibility of setting differential charges for different groups such

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[10] This is based on the total service cost of $32.9 million incurred in 1989/90 providing 238 000 visits by Government and subvented sectors.

as maternity cases and elderly should be explored.

13.27. For DOT service, the present charge is $30 per visit. We recommend that the same principles in determining charges for CNS should apply to charges for DOT service.

Implementation

Strategy

13.28. To take account of the realities of limited resources and to ensure that prompt improvements could be made particularly to services the development of which has been neglected in the past, we have considered an implementation programme for our recommendations. Such a programme is also necessary as implementation of some of the recommended measures would require extensive planning and preparation and depend on the availability of trained manpower.

13.29. We recommend a gradual, step-by-step approach in implementing our recommendations. Innovative ideas to improve existing services should generally be implemented on a pilot basis and in the course of implementation, there should be scope for revision and adjustment. Action-oriented projects should be initiated wherever appropriate and these should be subject to detailed evaluation prior to wider application throughout the service.

13.30. To support such an implementation strategy, the importance of **health services research** should not

be overlooked. Changes in epidemiology, demographic situation, medical technology and public expectations demand adjustments to how primary health care services should be delivered. Without timely provision and analysis of the necessary data to planners and decision-makers, the services are likely to become outdated either in terms of their objective or mode of delivery. This is what has happened in the GOP service. We therefore recommend that the Department of Health should have the capability and resources to carry out health services research in collaboration with other parties on an on-going basis as an essential part of the strategy to implement reforms.

13.31. Health services research should not be confined to Government and academic sectors. Private practitioners, medical associations and other health care professionals should also be encouraged to explore health needs of the community or to put their innovative ideas in improving patient care into practice. To encourage these endeavours, we recommend the setting up of a Health Services Research Fund. Its purposes would be to promote health services research and to provide financial assistance to such projects. This fund could be created from private charities, public resources or support from the health care-related industry.

Programme

13.32. We have broadly categorized our recommendations into those which should be implemented immediately, those to be implemented in the medium term and others for longer-term implementation.

13.33. For recommendations to be implemented immediately, we expect these to commence within 12 months after acceptance by the Administration. These are further classified into the following -

(a) Training-related

(i) development of training centres in primary health care at the Ngau Tau Kok Clinic and the Yan Oi Polyclinic;

(ii) expansion of the training capacity of the Public Health Nursing School;

(iii) strengthening undergraduate and postgraduate training in general practice at the two universities;

(b) Organizational and structural changes

(i) preparation for the establishment of the Primary Health Care Authority including drafting of the necessary legislation;

(ii) re-organization of the Department of Health;

(iii) experimenting the District Health System and developing the Ngau Tau Kok Clinic and the Yan Oi Polyclinic into District Health Centres;

(iv) developing one or two clinics in collaboration with the private sector;

(c) <u>Improvements to services on the basis of the existing infrastructure and mode of delivery</u>

(i) improvements to delivery of service at GOP clinics;

(ii) enhancement of existing health education activities;

(iii) strengthening the present system for the surveillance of communicable diseases;

(iv) providing oral health education and counselling to pre-school children attending MCH centres;

(v) developing a better career structure for GOP doctors;

(d) <u>Research and evaluation-related</u>

(i) establishment of a Health Information System and development of health services research including the setting up of a Health Services Research Fund;

(ii) formation of an advisory committee and the necessary expert working groups to advise on development of health indicators and protocols for screening programmes;

(iii) a study on the financing of health and medical services in Hong Kong; and

(iv) a comprehensive review of occupational health service.

13.34. For recommendations to be implemented in the medium term, we expect these to take place within two to three years after acceptance by the Administration in view of the lead time required to first improve the service or train the necessary staff. This category of proposals include -

(a) setting up a Primary Health Care Authority;

(b) introducing the Student Health Service in place of the School Medical Service;

(c) introducing screening services for the elderly and at-risk groups at selected GOP clinics and well-woman clinics at two MCH centres;

(d) further development of training in family medicine and community medicine through the future Academy of Medicine;

(e) with visible improvements in the GOP service, phased introduction of a new charging policy at GOP clinics using the target group approach; and

(f) developing CNS and DOT as integral parts of primary health care services and adopting a new basis for setting charges for CNS and DOT services.

13.35. Recommendations for longer-term implementation are those which would depend on the success of the pilot schemes and the action-oriented research projects and completion of the proposed reviews. These include further application of the District Health System gradually throughout the territory and development of some form of centrally managed health insurance scheme. We hope these could take place within the next five to seven years.

CHAPTER FOURTEEN

FINANCING OF HEALTH CARE SERVICES

Introduction

14.1. "During the last twenty years, the payment for and the delivery of health care have become acute political and economic problems in countries at all levels of development and with quite different social structures and political systems. There are three underlying reasons. The **first** is that technological developments have been making the provision of good health care increasingly expensive -- particularly in countries with ageing populations. The **second** reason is lower worldwide rates of economic growth and in some countries actual declines in growth and formidable problems of international indebtedness. The **third** is the political pressure in an increasing number of countries to make health care available to all citizens.... The response to these conflicting pressures has been a worldwide search for the best ways of containing costs, promoting efficiency and securing that quality health care is geographically available wherever it is needed. As a result there has been a new wave of experiment and innovation in ways of financing health care and particularly in ways of paying professionals and agencies providing it."[1]

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[1] From Professor Brian Abel-Smith, "World Trends in Health Care Financing and Delivery", paper presented at the International Symposium on Health Care Systems, 18-20 December 1989, Taiwan.

14.2. Although we are fortunate in having a public sector health system which over the past years has provided a virtually free, easily accessible and practically universal service, Hong Kong is not spared the problems of escalating costs and finite resources. While we are working on our recommendations in respect of primary health care, there has been much public discussion and debate on the financing of health and medical services in Hong Kong. This is partly in response to the worldwide search for ways and means to provide quality care while containing health costs and partly as a result of concern over PHA's proposal to revise the charging policy in respect of public hospital services. Facing the future of greater health needs, an ageing population, more costly medical technology and with the setting up of the Hospital Authority and a new approach towards primary health care, we believe that **the time is right** for Government to take a critical look at the overall financing of health care services, including hospital services, in Hong Kong.

Objectives for a Health Care System

14.3. Health care systems cannot be simply transplanted from one country to another. Each country has to take into account its own tradition, social, economical and political conditions in devising its own health care system. However, what is universally required before embarking on a review of an existing system or proceeding to implement a new system is the need for clearly defined objectives.

14.4. In our view, a desirable health care system should meet the following objectives -

(a) **Equity** : in terms of provision of services, no one should be deprived of access to adequate services either due to geographical non-availability or lack of means; in terms of financing, the cost of medical and health care should be spread more equally over the community;

(b) **Cost control** : the overriding principle is not only to contain public expenditure on health but to control the overall health costs at a level the society can afford;

(c) **Efficient use of resources** : this requires the provision of services which will achieve the maximum health outcome with the minimum administrative costs;

(d) **Freedom of choice** : the patient should be free to choose a doctor or a health care facility at a cost he can afford and is prepared to pay; and

(e) **Quality care** : this refers to not only quality service at today's standards but also innovation and progress in health care practices to the benefit of patients.

Health Care Systems : the Experience of Other Countries

14.5. As a working party tasked to review primary health care, we have neither the time nor resources to undertake a detailed analysis of health care systems in other countries. However, from information obtained through individual members attending the International

Symposium on Health Care Systems[2], we are aware that the modes of financing health care services can be grouped into three broad categories as briefly described in the following paragraphs.

(a) <u>State funded and managed universal health insurance schemes</u>

14.6. The common characteristics of these systems are universal coverage, central management by government at the state or provincial level and freedom of choice of doctors and health care facilities subject to restrictions in terms of the scope of service covered or level of fees reimbursable in certain systems. These systems are funded from general taxation or by a special levy. The National Health Service in the United Kingdom, the health care system in Canada, Australia's Medicare and Singapore's Medisave[3] are variations of this scheme.

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[2] See paragraph 2.12 in Chapter Two.

[3] Singapore's Medisave Scheme is strictly speaking not a health insurance scheme. It is a **savings** scheme under which each employee and self-employed person puts aside a percentage of his monthly income in his Medisave Account to meet future hospitalization expenses. A person whose Medisave balance is not enough to cover the hospital bill may settle the outstanding bill from his future Medisave contributions. To help Singaporeans to meet the high medical costs arising from treatment of serious illnesses, a new scheme called MediShield has been recently introduced. This is a low-cost medical insurance plan with a premium ranging from S$1 to S$8 a month and maximum claims of up to S$15,000 a year and S$50,000 for a lifetime subject to certain limits.

(b) Compulsory health insurance schemes which achieve universal coverage but are not state funded or managed

14.7. This is the system operating in the Federal Republic of Germany and Japan. Universal health insurance coverage is achieved through statutory requirements and this is often evolved from schemes requiring compulsory health insurance for only a certain sector of the population. For example, the genesis of the German system was the statutory sickness fund first introduced for blue-collar employees back in 1883. This statutory health insurance system is characterized by a diversity of insurance plans or funds but a highly regulated fee schedule, negotiated between the associations of the health care providers and the associations of operators of insurance plans. In this system, the government is only supervising the statutory health insurance system and ensuring comprehensive coverage by subsidizing the destitute and the highest-risk groups such as the elderly but is not running the scheme itself.

(c) A "public-private mix" with government-run and privately managed health insurance schemes

14.8. This pluralistic mix is operating in the USA. The public system comprises the federally financed and administered Medicare programme for the elderly and the federal-and-state-financed and state-administered Medicaid programme for the poor. For those American citizens falling outside these two programmes, the bulk of their health care is financed through private, employer-provided health insurance schemes. Still others have their own health insurance policies or pay out-of-pocket at the point of service. It is estimated that up to 15% of the population under the age of 65 in

the USA or some 37 million are not covered by any form of health insurance.

14.9. Without going into a detailed analysis, it is evident that different health care financing systems are meeting the principal goals and objectives stated in paragraph 14.4. to a varying extent[4]. For

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[4] The relative success of different modes of financing health care services in cost containment can be inferred from these nations' total health expenditure over the years -

Total health expenditure as a percentage of Gross Domestic Products

	1960	1970	1980	1986
Australia	4.6	5.0	6.6	6.8
Canada	5.5	7.2	7.4	8.5
Germany	4.7	5.5	7.9	8.1
Japan	3.0	4.6	6.6	6.7
UK	3.9	4.5	5.8	6.2
USA	5.2	7.4	9.2	11.1

Source: Schieber, George J. and Poullier, Jean-Pierre, "Data Watch : International Health Spending and Utilization Trends, " Health Affairs, Vol. 7, No. 4, Fall, 1988; pages 105-12.

For comparison, it is estimated that Hong Kong spent about 4% of its GDP on health in 1986. This estimate is derived from the total public expenditure on health ($4,454 million) and private consumption expenditure on medical expenses ($7,377 million) out of the total expenditure on GDP ($300,818 million).

Source : Hong Kong Annual Digest of Statistics 1989 Edition, Census & Statistics Department

Central Finance Unit, HSD

instance, whilst equity and cost control are achieved in national health schemes, these systems are said to stifle innovative clinical practices and to have to ration technologically-advanced and expensive treatment services. Thus, they may not fare as well with the objectives of quality care. It is therefore up to the individual government to set its own priorities in developing the health care system having regard to the following economic and political realities -

(a) that health care is expensive and there is already evidence that the costs of providing medical services is rising faster than inflation and most other public services;

(b) that resources which can be devoted to health care are finite and have to be used efficiently to ensure maximum value for money;

(c) that community aspirations are growing and the perceived needs of services by patients and of facilities by health care providers are bound to exceed what available resources could provide;

(d) that the need for medical care is a contingency for which the individual should make some provision for himself and there should be a more equitable sharing of the health costs; and

(e) that in every society, there remains a certain proportion of the population who cannot take care of themselves and medical coverage for these people is fundamental to the maintenance of social and political stability.

Developing a Hong Kong Health Care System

14.10. In the course of our discussions, we have considered the introduction in Hong Kong of universal health insurance in the form of a centrally funded and managed scheme. The introduction of national health insurance would require very detailed investigations which we have neither the brief nor expertise to conduct. However, we foresee a wide range of complex problems.

14.11. The first and foremost problem is the source of funding. Any type of health insurance schemes providing universal coverage to all citizens would require a very substantial increase of resources, either by allocation of more public funds to the health programme or more realistically, by some form of contribution from the recipients of the service. The latter may be in the form of a compulsory levy on all salaried workers in addition to the existing salaries tax with the revenue yield going to meeting all or part of the costs of health services, regardless of whether such services are to be provided by the public sector or private practitioners. Under the present circumstances, it is said by some that such a scheme would raise the following problems -

(a) it would result in an increased tax which would reduce the attractiveness of Hong Kong as an investment centre at a time when every effort is being made to maintain our economic performance against fierce competition from industrializing territories in the same region;

(b) the scheme envisages revenue from the levy to be used solely on funding health services. This arrangement would amount to a hypothecation of government revenue, which is regarded as constraining government's ability to prioritize its expenditure according to needs and reducing incentives to economize; and

(c) Hong Kong has a very narrow tax base. If this levy were to be payable only by those already paying salaries tax, it would be neither fair nor acceptable. If all salaried workers were liable for the levy, it would amount to widening the tax base. The objections towards such a move and the likely destabilizing effect that it might have on society should not be overlooked. It would also raise the question of whether a central provident fund should first be put in place.

14.12. We have also considered the introduction of universal insurance schemes for employees. In this respect, we are aware that there are noticeable signs of a growing private medical insurance market in Hong Kong with the active involvement of employers. While we strongly recommend the development of private insurance schemes and suggest that measures to encourage their development should be adopted by Government, we have reservations on whether this should be made a mandatory requirement for the time being.

14.13. As a result, we have settled for the continuation of the present dual system -- a public system and a private system -- at least for some time to

come. We are, however, not entirely comfortable with this arrangement as experience overseas has clearly indicated that some form of universal and centrally managed scheme would be more capable of ensuring access to choice of care and containing health costs in the long run. While there is still a certain degree of public-private mix in all these schemes, the merits of central management include -

(a) collective bargaining in determining the charges for medical and health services;

(b) quality control and auditing to discourage over-treatment and to keep administrative costs to a minimum; and

(c) proper regulation to prevent abuses by the users, the service providers or the insurers.

14.14. Industrialized countries like the United Kingdom and Canada have a national or state-run scheme in place for many years. Countries like West Germany and Japan have a health care system characterized by comprehensive statutory insurance coverage. The newly industrialized countries like Taiwan, Singapore and South Korea are heading in the direction of a centrally managed scheme. Hong Kong is in need of an overall direction.

14.15. We therefore recommend that Government should conduct a study leading to a policy statement on the future financing of health and medical services in Hong Kong. This proposed study should aim at clearly defining the role and responsibilities of Government in providing quality health care to the community and the

respective contribution expected of the other parties, i.e. the employers and the patients themselves. The public should be given an opportunity to voice their opinion. In any event, if universal health insurance is to be introduced in Hong Kong, it has to meet with prior public acceptance. Attitudes of the community towards health insurance should be gauged at the beginning rather than at the end of the process leading to the formation of a health care financing strategy. Care must be taken to ensure proper understanding of the purposes of developing a strategy for financing health care services in Hong Kong. The public should be re-assured of Government's stated policy that no one should be prevented, through lack of means, from obtaining adequate medical treatment.

CHAPTER FIFTEEN

THE WAY AHEAD

Introduction

15.1. The aim of the WHO programme of 'Health For All by the Year 2000', launched at the Alma-Ata Conference in 1978, is to achieve significant improvement in primary health care. As we have already crossed the half-way point between the Alma-Ata Conference and the year 2000, we are looking forward to a health care system not only for the year 2000, but one which would be attuned to the needs of our community into the twenty-first century.

15.2. Systems of health care are usually the result of a process of evolution. We have therefore recommended a **gradual, step-by-step approach** in improvement to the delivery of primary health care in Hong Kong. Where improvement may be made on the basis of the existing infrastructure or mode of service operation, we propose that resources should be made available for immediate implementation. Where new schemes or initiatives in the delivery of primary health care are proposed, we advocate that pilot projects and models should be developed and fully evaluated prior to their application territory-wide. This approach would assure the community as well as the primary health care personnel of Government's commitment to improvement. However, these short-term measures should be in line with the long-term development of primary health care. The ultimate objective is to establish a health care

respective contribution expected of the other parties, i.e. the employers and the patients themselves. The public should be given an opportunity to voice their opinion. In any event, if universal health insurance is to be introduced in Hong Kong, it has to meet with prior public acceptance. Attitudes of the community towards health insurance should be gauged at the beginning rather than at the end of the process leading to the formation of a health care financing strategy. Care must be taken to ensure proper understanding of the purposes of developing a strategy for financing health care services in Hong Kong. The public should be re-assured of Government's stated policy that no one should be prevented, through lack of means, from obtaining adequate medical treatment.

CHAPTER SIXTEEN

SUMMARY OF RECOMMENDATIONS

This chapter contains a summary of our recommendations.

Chapter Four : Objectives and Principles

1. We recommend that the role of Government in the development of primary health care in Hong Kong should be :

   (a) to safeguard the public health of the community and minimize the incidence of preventable disease and disability through provision of quality and efficient preventive care services; and

   (b) to ensure the provision of a framework for the delivery of continuing, comprehensive and whole-person medical care to individuals in their home or natural environment.

   (Paragraph 4.7)

Chapter Five : Health Promotion and Disease Prevention

We recommend that :

2. The Department of Health particularly its Central Health Education Unit should continue to play a

major and leading role in health education activities.

(Paragraph 5.9)

3. There should be a well-defined policy on health education and promotion which should meet the targets and objectives as stated in paragraph 5.10.

(Paragraph 5.10)

4. Systematic planning should be adopted for educating the public on healthy lifestyle and self-care which are conducive to both physical and mental health.

(Paragraph 5.11)

5. Priority in health education should be given to the following health problems -

(a) smoking;

(b) mental health;

(c) alcohol abuse;

(d) AIDS and sexually transmitted diseases;

(e) accidental poisoning and injury;

(f) diet control and healthy eating habits;

(g) regular exercise; and

(h) drug abuse.

(Paragraph 5.12)

6. The Central Health Education Unit should be re-organized into a specialist service, headed by a person who is knowledgeable in educational principles, communication skills and experienced in research but who does not need to be medically qualified.

(Paragraph 5.13)

7. More training opportunities such as postgraduate training in health education and training in communication skills should be provided to medical and nursing staff working at the Central Health Education Unit. Training programmes should also be organized for other health educators and intermediaries such as school teachers, social workers and volunteers.

(Paragraph 5.13)

8. An audio-visual production team of one Programme Officer, one Assistant Programme Officer and three Technical Officers II should be established in the Central Health Education Unit.

(Paragraph 5.14)

9. Membership of the existing Health Education Co-ordinating Committee should be strengthened with stronger representation from public and private sectors and greater community participation.

(Paragraph 5.15)

10. Health care professionals should be more actively involved in health education.

(Paragraph 5.16)

11. A higher coverage of measles vaccination should be achieved and "mop-up" measles immunization programmes for Primary One school children should be launched to catch those who have missed the standard immunization provided at age one under the programme.

(Paragraph 5.19)

12. The immunization programme should continue to be supported by -

(a) vigilance over defaulters by health staff at the maternal and child health centres and regional health offices;

(b) sustained health education efforts to promote the importance of inoculation and vaccination; and

(c) effective data collection and analysis to monitor the morbidity and mortality trends.

(Paragraph 5.20)

13. The immunization schedule should continue to be kept under regular review by the Advisory Committee on Immunization.

(Paragraph 5.20)

14. The Department of Health should examine the continuing need for maternity homes having regard to the availability of alternatives for those seeking maternity services.

(Paragraph 5.25)

15. The existing maternal and child health service should be improved by providing oral health education and counselling to parents at maternal and child health centres; by incorporating the child's records maintained at this centre into the health booklets to be issued to students for their own keeping under the proposed Student Health Service; and by providing preventive care services to women at well-woman clinics to be established as part and parcel of the Family Health Service.

(Paragraph 5.29)

16. The surveillance system for the control of communicable diseases should be strengthened by updating, improving and simplifying the communicable disease notification form (MD 1) to facilitate notifications; by introducing an epidemiological bulletin to improve communication

between the Department of Health and all medical practitioners and by strengthening the epidemiology unit within the Department of Health to take on new responsibilities.

(Paragraph 5.40)

17. An overall review of occupational health services in Hong Kong should be carried out taking into account changing practices in industry and the modern day concepts of occupational health.

(Paragraph 5.43)

18. To improve the occupational health of Hong Kong's workforce, the following areas should be accorded particular attention -

(a) employers should be encouraged to provide occupational health services in the workplace;

(b) primary care doctors should be encouraged to orientate their practice to put greater emphasis on the occupational history of their patients;

(c) doctors participating in medical care schemes for employees should be trained to provide occupational health services;

(d) more training opportunities on occupational health services should be provided for health care professionals, workers and management;

(e) training opportunities, grade structure and promotion prospects of doctors, hygienists and nurses in the Occupational Health Division should be reviewed and improved;

(f) workers should be encouraged to take a more active part in promoting healthy working environments and working conditions for themselves and the public at large should be educated on the importance of occupational health; and

(g) greater attention should be given to the medical and health aspects of occupational safety and health through strengthened co-ordination between the Labour Department and the Department of Health and closer liaison between the Occupational Health Division and hospitals and clinics.

(Paragraph 5.47)

19. Promotion of mental health should be strengthened.

(Paragraph 5.49)

20. Mental health education should be strengthened both at the undergraduate and postgraduate level in medical education, particularly in vocational training in family medicine.

(Paragraph 5.50)

21. Collection, analysis and utilization of information about health should be substantially improved.

(Paragraph 5.54)

22. A computer-based clinical information system should be developed in the general out-patient service.

(Paragraph 5.59)

23. A proposed three-year programme to be conducted by the Department of Health in collaboration with the University of Hong Kong for the development of a clinical information system in general out-patient service should commence as soon as possible.

(Paragraph 5.60)

24. The present Statistical Unit in the Department of Health should be strengthened and expanded to become a Health Information Unit.

(Paragraph 5.61)

Chapter Six : Screening Services

We recommend that :

25. Screening programmes targeted towards diseases or population sub-groups should be more

cost-effective than general population screening in the local context.

(Paragraph 6.5)

26. Well-woman clinics providing preventive health service to women of all ages should be set up as part and parcel of the Family Health Service. As a first step, such services should be provided on a pilot basis at two maternal and child health centres.

(Paragraph 6.9)

27. Opportunistic screening should be introduced for the elderly aged 65 and above attending general out-patient clinics.

(Paragraph 6.18)

28. Consideration should be given to the introduction of opportunistic screening for patients attending general out-patient clinics who are aged 45 to 64 having regard to their health status, medical history and the mortality and morbidity patterns in Hong Kong.

(Paragraph 6.19)

29. The existing screening programmes for women of child-bearing age, newborns and pre-school

children should continue and a comprehensive screening programme for students under the new Student Health Service should be introduced.

(Paragraph 6.21)

30. New initiatives in the further expansion of Government provision of screening programmes should be built on the existing infrastructure in order to bridge an obvious gap in screening services and to strengthen health promotion and disease prevention for certain specific groups. These new initiatives should be conducted on a pilot basis linked to a detailed evaluation plan. Expert working groups should be set up to design the details of each of the various screening services, the appropriate screening protocols and the evaluation plan.

(Paragraphs 6.23 and 6.25)

31. An advisory committee should be formed to evaluate the overall effectiveness of the opportunistic case-finding approach to screening and to advise on the need for more screening on the basis of the findings of the evaluation and the adoption of other approaches.

(Paragraph 6.26)

Chapter Seven : Student Health Services

We recommend that :

32. The School Medical Service should be abolished in favour of a mainly preventive and promotive Student Health Service to be operated by the Department of Health.

(Paragraph 7.38)

33. The goal of the new Student Health Service should be to promote and maintain the health of school children so that they can derive maximum benefit from the education system.

(Paragraph 7.43)

34. The objectives of the Student Health Service should be -

(a) the promotion of desirable health knowledge and practice for motivation of self-care and individual responsibility in health;

(b) the prevention of ill health and disease through timely vaccination and early detection of health and educational problems; and

(c) the provision of facilities for the further assessment of defects or disorders and referral to early treatment and rehabilitation services.

(Paragraph 7.44)

35. The Student Health Service should comprise eight components as stated in paragraph 7.45.

(Paragraph 7.45)

36. A separate non-regionalized division should be set up within the Department of Health to plan and implement the Student Health Service. The planning and development of the Student Health Service should have the benefit of an advisory committee comprising school principals or teachers, private practitioners, parents, representatives of the medical and dental associations, the Education Department and the Social Welfare Department.

(Paragraph 7.54)

37. The Department of Health should monitor the utilization of general out-patient clinic service by students and make appropriate adjustments in the light of the demand for service in each district.

(Paragraph 7.62)

38. Allowing time for planning and assuming that resources are forthcoming, the school-based programmes of the Student Health Service should be introduced in stages, commencing in the school year 1992/93.

(Paragraph 7.64)

39. The Department of Health and the Education Department should jointly consider the feasibility of integrating the Combined Screening Programme with the Student Health Service and to decide on the best timing of such integration.

(Paragraph 7.66)

Chapter Eight : Delivery of Primary Medical Care in Clinic Service

We recommend that :

40. The objectives of the Government primary medical care service should be to provide quality primary medical care which is readily accessible and affordable, with special attention and provision for certain target groups, and which will act as a benchmark for the delivery of service in Hong Kong.

(Paragraph 8.33)

41. Provision of training for general out-patient doctors, whether in the form of vocational training leading to a further qualification or continuing medical education to update their skills and knowledge, should be accepted as a priority in the development of the general out-patient service.

(Paragraph 8.37)

42. Nurses in the general out-patient service should receive special training to equip them for the extended responsibilities including the role of a health practice nurse. The use of clinic assistants to carry out certain designated duties in order to achieve a better match of skills to tasks should also be considered.

(Paragraph 8.38)

43. The career prospects of doctors in the general out-patient service should be improved.

(Paragraph 8.39)

44. The system of manual medical records for individual patients introduced on a pilot basis at four general out-patient clinics should be extended to other general out-patient clinics as soon as possible. The ultimate objective should be to computerize the clinical information system and link up the records with other units in the same clinic as well as with other clinics.

(Paragraph 8.41)

45. To improve preventive care, opportunistic screening for certain common diseases among the high-risk groups attending general out-patient clinics should be introduced. General health counselling about diet, weight and cholesterol should be provided by nurses at general

out-patient clinics while doctors should provide more specific counselling in relation to the patient's health problem in the course of the consultation.

(Paragraph 8.42)

46. The practice of labelling dispensed medicines should be introduced at the general out-patient clinics.

(Paragraph 8.43)

47. The Department of Health should give urgent attention to the various clinic management issues affecting workloads with a view to reducing the patient load of general out-patient doctors in order to provide longer consultation duration for each patient.

(Paragraph 8.45)

48. The necessary improvements to clinic environment and support facilities should be identified with the co-operation of doctors in the clinics and the management should respond to these needs.

(Paragraph 8.46)

49. Efforts should be made to motivate the doctors to make the best use of the time available for each

consultation and to educate the patients to comply with the appointment schedule. An advance appointment system should be developed for patients suffering from chronic diseases who require follow-up consultation at regular intervals.

(Paragraph 8.48)

50. Separate accounting arrangements should be introduced within the Department of Health's overall budget so that the costs of providing primary medical care service to civil servants, retired civil servants and their dependants could be identified separately from those for members of the public. In the long run, alternative arrangements for providing primary medical care services for members of the civil service should be given due consideration by the Administration.

(Paragraph 8.51)

51. Private practitioners should be given more opportunities for training in family medicine.

(Paragraph 8.55)

52. The Hong Kong College of General Practitioners and the medical associations should play an active role in encouraging peer review.

(Paragraph 8.56)

53. Group practice should be promoted in Hong Kong and the proposed arrangements for collaboration between the public and private sectors should facilitate such a development.

(Paragraph 8.57)

54. Private practitioners in primary and specialist care should maintain a close liaison and ensure an adequate two-way flow of information when patients are referred.

(Paragraph 8.58)

55. Private practitioners should keep good medical records and give a detailed explanation to patients of their specific medical problems.

(Paragraph 8.59)

56. Private practitioners should adopt the practice of labelling dispensed medicines.

(Paragraph 8.60)

57. Private practitioners should give greater priority to providing promotive and preventive health care and counselling to their patients.

(Paragraph 8.61)

58. The proposed clinics for collaboration should be developed on a pilot basis involving one or two clinics, preferably in a fairly newly developed and geographically isolated area.

(Paragraph 8.68)

59. Primary care doctors should be provided with the necessary basic training, exposure and experience in various medical specialties so as to enable them to be more competent in handling patients and in determining the appropriate time to refer patients to the appropriate specialist service.

(Paragraph 8.82)

60. Additional specialist mini-clinics on a sessional basis should be set up at the general out-patient clinics to be run jointly by specialists from hospitals and general out-patient doctors.

(Paragraph 8.83)

61. With the introduction of medical records for individual patients at the general out-patient clinics, referrals to specialist service should be accompanied by a written report containing as much details as possible on the patient's medical history and the referring doctor's observations and diagnosis.

(Paragraph 8.84)

62. Additional resources should be given to the general out-patient clinics to take care of the increasing number of patients referred to them for follow-up care from the specialist services.

(Paragraph 8.85)

63. A study into the operation of specialist clinics should be accorded priority by the Hospital Authority.

(Paragraph 8.88)

Chapter Nine : Community Health Services and Rehabilitative Care

We recommend that :

64. The objectives of community nursing service should be re-defined in the form of a mission statement, a set of service objectives that would facilitate evaluation and a more clearly defined scope of service.

(Paragraph 9.7)

65. Community nursing service should continue to be universally accessible.

(Paragraph 9.8)

66. Community nursing service should be organized as a primary health care service and that this arrangement should be introduced on a pilot basis in the two primary health care districts to be set up.

(Paragraph 9.10)

67. The development of domiciliary occupational therapy service should be promoted and active consideration should be given to the development of an integrated domiciliary rehabilitation team comprising domiciliary occupational therapy, physiotherapy and other paramedical services.

(Paragraph 9.16)

68. The elderly should be one of the most important target groups for receiving primary health care.

(Paragraph 9.27)

69. A more integrated approach to providing community health services for the elderly should be adopted under the primary health care system with a view to promoting the health and well-being of the elderly through provision of community-based services, with the maximum participation of everyone including the elderly themselves.

(Paragraph 9.31)

70. Community health services for the elderly should have the objectives as stated in paragraph 9.32.

(Paragraph 9.32)

71. The Central Health Education Unit of the Department of Health should adopt a more targeted approach to promote health education among the elderly.

(Paragraph 9.33)

72. Consideration should be given to the setting up of a more permanent committee to co-ordinate activities in community education on ageing and to advise on strategies, themes and targets of such activities.

(Paragraph 9.35)

73. Health programmes and messages through the mass media on ageing should be strengthened.

(Paragraph 9.36)

74. The Department of Health should develop a health screening protocol for the reference of organizations which conduct health screening programmes for the elderly.

(Paragraph 9.37)

Chapter Ten : Training of Health Care Personnel

We recommend that :

75. More resources should be devoted to training in family medicine at the undergraduate level and if possible, a separate department of family medicine should be established at both universities to reflect the growing importance of this discipline.

(Paragraph 10.10)

76. More and better clinic facilities should be made available to the universities for undertaking postgraduate education in family medicine.

(Paragraph 10.14)

77. Training centres in primary health care should be set up by the Department of Health at the Ngau Tau Kok Clinic and the Yan Oi Polyclinic.

(Paragraph 10.22)

78. Suitable arrangements should be devised to seek the assistance of the medical faculties and the Hong Kong College of General Practitioners to ensure an adequate supply of trainers.

(Paragraph 10.25)

79. Support should be given to the development of more local training in community medicine.

(Paragraph 10.28)

80. Short-term training attachments to the relevant medical specialties for government doctors involved in the delivery of primary health care should be further developed.

(Paragraph 10.29)

81. Government doctors in primary health care should be provided with opportunities for management training to better equip themselves to co-ordinate, manage and evaluate the services for which they are responsible.

(Paragraph 10.29)

82. The idea of having clinic assistants to assist fully-trained nurses in the less technical work at general out-patient clinics should be tested.

(Paragraph 10.34)

83. The training capacity of the Department of Health's Public Health Nursing School should be expanded as a matter of urgency. The Department of Health should also explore with the universities and the Hong Kong Polytechnic the

possibility of organizing post-basic courses in public health nursing.

(Paragraph 10.35)

84. The possibility of putting community nurse training under the auspices of the Department of Health's Public Health Nursing School should be explored.

(Paragraph 10.39)

85. Consideration should be given to the introduction of formal training in health education whether in the form of structured post-basic courses for health care personnel or part-time programmes for other intermediaries at tertiary institutions.

(Paragraph 10.44)

Chapter Eleven : The District Health System

We recommend that :

86. Primary health care services should be organized and administered on the basis of a District Health System.

(Paragraph 11.2)

87. The Ngau Tau Kok Clinic and the Yan Oi Polyclinic should be developed into District Health Centres

serving as the headquarters of the Kwun Tong and Tuen Mun Primary Health Care Districts respectively.

(Paragraph 11.15)

88. The various measures proposed to improve existing services should also be introduced in these two District Health Centres on a pilot basis.

(Paragraph 11.16)

89. A mechanism should be developed for the close monitoring and effective evaluation of the operation of the District Health Centres and the various pilot projects.

(Paragraph 11.20)

Chapter Twelve : Structure for the Delivery of Primary Health Care

We recommend that :

90. A statutory Primary Health Care Authority with some degree of financial autonomy, and with the Department of Health as its executive arm should be established to oversee the delivery of primary health care in Hong Kong.

(Paragraph 12.15)

91. Immediate action should be taken to re-organize and strengthen the Department of Health to facilitate early improvement to the delivery of primary health care and to pave the way for the setting up of the Primary Health Care Authority.

(Paragraph 12.16)

Chapter Thirteen : Funding and Implementation

We recommend that :

92. Preventive care services including immunization, maternal and child care, family planning, student health and other services conducive to the control of communicable diseases should continue to be provided free of charge.

(Paragraph 13.12)

93. Health screening services for the elderly and at-risk groups aged 45 to 64 attending general out-patient clinics and women attending well-woman clinics should be provided at a charge, with reduced charges offered to those target groups identified for subsidized primary medical care at general out-patient clinics. For those who cannot afford to pay, the present arrangement for charges to be waived should apply.

(Paragraph 13.13)

94. A charging policy, which identifies target groups for subsidized service at general out-patient clinics, in keeping with Government's policy that no one should be prevented, through lack of means, from obtaining adequate medical treatment, should be adopted.

(Paragraph 13.16)

95. Target groups for subsidized primary medical care should include -

(a) Young children aged 0 to 15 and full-time students up to the age of 18 (half fee);

(b) the elderly, aged 65 and above (half fee);

(c) recipients of disability allowances (half fee); and

(d) recipients of public assistance (free of charge).

(Paragraph 13.19)

96. The level of fees at general out-patient clinics should be set according to the principles that -

(a) non-target group patients should not be charged above cost in order that the fees collected could go to subsidizing the target groups. Subsidy for the needy should remain Government's responsibility;

(b) charging non-target group patients at cost should be the eventual aim. This should be achieved gradually with visible improvement in the quality of service.

(Paragraph 13.22)

97. Fees for community rehabilitative services should continue to be set at a highly subsidized level.

(Paragraph 13.25)

98. Charges for community nursing service and domiciliary occupational therapy service should be calculated and expressed as a percentage of the cost of the service and be regularly updated on this basis. These charges should continue to be set at a substantially subsidized rate and at a flat rate for all with the existing mechanism for waiving of fees.

(Paragraphs 13.26 and 13.27)

99. A gradual, step-by-step approach should be adopted. Innovative ideas to improve existing services should generally be implemented on a pilot basis and in the course of implementation, there should be scope for revision and adjustment.

(Paragraph 13.29)

100. The Department of Health should have the capability and resources to carry out health services research in collaboration with other parties on an on-going basis as an essential part of the strategy to implement reforms.

(Paragraph 13.30)

101. A Health Services Research Fund should be set up.

(Paragraph 13.31)

<u>Chapter Fourteen : Financing of Health Care Service</u>

102. We <u>recommend</u> that Government should conduct a study leading to a policy statement on the future financing of health and medical services in Hong Kong.

(Paragraph 14.15)

Appendix 1

Membership of the Working Party

Chairman	Professor Rosie T T YOUNG, OBE, JP
Members	Professor S P B DONNAN (until 12.05.1990) Professor P C LEUNG (from 13.05.1990) (nominated by The Chinese University of Hong Kong)
	Professor John C Y LEONG (nominated by the University of Hong Kong)
	Dr Anthony NG (nominated by the Hong Kong Medical Association)
	Dr Christopher D ADAMSON-LUND (nominated by the British Medical Association, Hong Kong Branch)
	Dr Peter C Y LEE, LLD, JP (nominated by the Hong Kong College of General Practitioners)
	Mr Donald CHIA
	Mrs Alice CHONG
	Miss Mona LO
	Miss Moyna WONG
	Mr YEUNG Po-kwan, OBE, CPM, JP

Ex Officio	Chairman, School Medical Service Board Dr Natalis C L YUEN, JP
	Director of Health Dr S H LEE, ISO, JP
	Deputy Director of Health Dr K H PANG, JP
	A representative of the Hospital Services Department Deputy Director of Hospital Services (Professional Services) Dr Lawrence F M LAI, JP
	A representative of the Finance Branch Assistant Financial Secretary Mr Brian BRESNIHAN
	A representative of the Health and Welfare Branch Principal Assistant Secretary for Health and Welfare Mrs Carrie LAM
Secretary	Assistant Secretary for Health and Welfare Mr G F WOODHEAD (until 31.05.1990) Ms Annie CHOI (from 01.06.1990)

Appendix 2

Written Submissions Received

Written submissions were received from the following bodies and individuals :

Association of Government Nursing Staff

British Medical Association, Hong Kong Branch

Caritas Medical Centre Doctors' Association

Consumer Council

Dr CHOW Chun-bong

Estate Doctors Association Limited

Federation of Hong Kong Industries

Government Doctors' Association

Hong Kong Association of Gerontology

Hong Kong Association of Speech Therapists

Hong Kong Chinese Civil Servants' Association, Nurses Branch

Hong Kong Chiropractors' Association

The Hong Kong College of General Practitioners

The Hong Kong College of Physicians

The Hong Kong Council of Social Service

Hong Kong Dental Association

The Hong Kong Geriatric Society

The Hong Kong Medical Association

The Hong Kong Nurses Association & the Hong Kong College of Nursing

Hong Kong Ophthalmological Society

Hong Kong Orthopaedic Association

Hong Kong Paediatric Society

The Hong Kong Pharmaceutical Manufacturers Association Limited

Hong Kong Polytechnic, Division of Health and Social Studies

Hong Kong Psychiatric Association

Hong Kong Society of Community Medicine

The Hong Kong Society for the Deaf

Hong Kong Society for Emergency Medicine & Surgery

The Hong Kong Society of Professional Optometrists

Professor Patrick C P HO

Professor F Lieh MAK

The Obstetrical & Gynaecological Society of Hong Kong

Provisional Hospital Authority

School Medical Service Board

School Medical Service Doctors Association

The Society of Homes for the Handicapped

Tung Wah Group Hospitals Doctors' Association

United Christian Hospital Doctors Association

Appendix 3

Summary of Surveys on Health and Medical Care in Hong Kong conducted by the Department of Community Medicine University of Hong Kong

Background

In September 1989, the Department of Community Medicine of the University of Hong Kong was commissioned by the Working Party on Primary Health Care to conduct a series of surveys on health care services in Hong Kong. The purpose of the surveys was to examine the working of GOP clinics, the utilization of maternal and child health services and utilization of health care services among the general population. Three separate surveys were conducted. The research team was headed by Professor A J HEDLEY and the report was submitted to the Working Party in March 1990.

Survey of GOP Clinics
(Health Problems, Patterns of Utilization, Medical Work and Outcomes in Patients Attending GOP Clinics)

The Sample

2. A survey of patients attending GOP clinics was carried out in 80 morning, afternoon, evening and Sunday/public holiday doctor sessions at 12 clinics. A large representative sample of 1 214 GOP clinic users was interviewed. The response rate for the interview was high, ranging from 82% for Sunday/public holiday clinic sessions to 89% for morning sessions.

Summary of Major Findings

3. The major findings of the survey are summarized below -

(a) Socio-demographic aspects - Clinic users were older and included more females than the general population; they were from lower income groups and had lower than average levels of educational attainment.

(b) Perceived health and health risks - The majority of those rating their health as poor or very poor were younger; 29% of males and

5% of females were smokers; 13% were regular users of alcohol.

(c) <u>Use of services and health beliefs</u> - Traditional health beliefs, including the 'hot/cold'(熱氣 / 寒涼) concept, were strong (89%) among GOP service users and over 40% were accustomed to making frequent changes of doctor ("shopping") - those least likely to shop were older and had chronic problems such as diabetes and hypertension.

(d) <u>Consultations and hospital admissions</u> - The frequency of consultation was higher among older people. Those with chronic problems and other illnesses of more than three months' duration had consulted at least once per month during the three months preceding the interview. Hospitalization rates were high among those with poor self-ratings of health but the highest rates for any sub-group (during the previous 12 months) were for children under the age of 12 (16%), together with patients with diabetes (26%) and other long-standing problems (16%). There was a correlation between higher frequency of consultation and higher rate of hospitalization.

(e) <u>Medical work in GOP clinics</u> - There was wide variation in throughput times between different clinics with similar workloads; but doctors often processed all patients well ahead of the clinic closing time.

(f) <u>Problems of GOP clinic users</u> - The majority (96%) of users had used GOP clinics before but both former and new clients came with new health problems. Respiratory problems (66%) were the biggest group of new complaints, with musculo-skeletal complaints (33%) and circulatory/respiratory problems (36%) being the commonest complaints among patients who came for an old problem.

(g) <u>Choices and utilization of health care</u> - 80% of clinic users had used some form of self-care including over-the-counter drugs (25%), left-over drugs (14%) or Chinese herbs (10%) and might have sought professional (39%) or lay (22%) advice before coming to

the GOP clinic. Patients suffering from a long-standing problem had mainly used government services previously whereas patients with new complaints and particularly first-time users had almost exclusively consulted a private doctor before.

(h) Characteristics of consultations - The outcomes of consultations were characterized by low levels of investigation and high levels of treatment. The majority of patients (70%) apparently left the clinic without knowing the presumptive diagnosis but only 2.5% of patients left the clinic without some form of medication. Most patients were prescribed three types of medicine, the average ranging from 2.4 (new patients) to 2.8 (former users).

(i) Recalls - Medical work created by recalls to the clinic ranged from 11% in patients with new problems to 20% in patients with old problems and 26% in those with diabetes and hypertension; this process was largely unstructured with many patients not told when to return.

(j) Referrals - Referrals to other units were relatively low; 4.9% of GOP patients were referred to specialist clinics and 0.57% to Accident & Emergency Departments; the contribution of GOP clinics to total specialist clinic workloads was estimated at 7.9%. Similarly GOP referrals were estimated to account for 2.1% to 4.2% of all admissions arising from Accident & Emergency attendances.

(k) Patients' expectations and extent of satisfaction - Overall patients' expectations were low and satisfaction levels generally high. The main source of dissatisfaction arose from aspects of clinic organization, including waiting time. Most patients (80%) expected some form of medication, although the younger and better educated patients were less likely to take this view. A further source of dissatisfaction concerned the low level of information disclosed during the consultation. The majority of GOP users would welcome the use of some form of patient-held record.

(1) Health care expenditure - 66% of clinic users had spent less than $100 in the previous three months preceding the interview on all types of health care, including consultations, hospitalization, medication and tonics. 17% had spent nothing and the majority of them were the older patients and those with chronic diseases.

Conclusions

4. The survey findings have identified several aspects in the management of clinics which should be reviewed and several areas in the contents and quality of care which should be improved. These include -

(a) the duration for consultation and the scheduling of appointments with a view to resolving the problems of rapid discharge of patients and early closing of clinics;

(b) development of comprehensive records and management protocols for patients with different types of medical needs especially those chronic cases who visit the GOP clinics frequently;

(c) modification of recall practices to provide more comprehensive and quality care and thus reduces the need for frequent visits which would benefit both patients and the service;

(d) improved health education which would facilitate a more rational use of health care services; and

(e) adoption of more innovative measures such as patient-held records and the use of non-medical personnel in the clinics.

Survey of Maternal and Child Health
(Health and Health Care Choices in a Sample of 300 Mothers and Infants)

The Sample

5. The pattern of preferences for maternal and child health care services was studied in a sample of infants and their mothers obtained from births registered in the territory. The study sample comprised 340 infants from a larger random sample of 3 230 originally selected for an earlier study. A total of 300 sampled mothers (88%) were successfully interviewed.

Summary of Major Findings

6. The major findings of the survey are summarized below -

(a) General health indices - The birth weights for the children indicated that, according to this criterion, they began life as a healthy population. The mean and modal birth weight was 3.2 kilograms and 70% of the infants fell in the band 2.5-3.4 kilograms. Only 2% weighed less than 2.5 kilograms. They were aged six months to three years at the time of the survey.

(b) Place and form of delivery - The majority of children were born in government (43%) or subvented hospitals (30%) followed by private hospitals (20%). 77% were delivered naturally. Caesarean cases accounted for 14% with the remainder requiring forceps or vacuum extractions. The age of their mothers ranged from 18 - 44 years. The mean age was 30.5 and the modal age was 39.

(c) Socio-economic status - Only 70% of respondents responded to inquiries on family income. Those who responded declared a monthly family income ranging from less than $1,000 to more than $10,000 with the modal value between $3,000 and $6,000. The majority lived in private housing (not shared) or public housing estates.

(d) Antenatal care - All except one mother received antenatal care, using either MCH centres alone or together with government and subvented hospitals (36%); a further 10% used government hospitals alone and 22% used subvented hospitals alone. Private practice provided antenatal care to 32% of mothers either alone or in combination with other services. Overall, government and subvented services were providing antenatal care in part or whole to 68% of mothers. Mothers chose antenatal care facilities mainly for convenience (57%) and confidence (11%). Satisfaction levels were relatively high, varying from 72% to 93% depending on the types of facilities used. Satisfaction was lowest for users of government hospitals alone and highest in those with predominantly

MCH use. Reasons for dissatisfaction with government hospitals included the appointment system. Whereas antenatal health education was rated highest for MCH centres, this feature was apparently lacking in other services. In contrast, significantly more users of private practice commented on the use of special tests such as ultrasound.

(e) Cost of antenatal care - There were marked variations in costs to the women surveyed according to the use of different types of services. The majority spent less than $500 on antenatal care. Those using public sector services spent less overall whereas 89% of those using the private sector spent more than $500 going up to $5,000 or more. In general, mothers' acceptance of the fees levied was high whichever service they used. 47% of mothers using MCH service thought that a fee could be charged for antenatal care and 96% of them would be willing and able to pay. In their view, an acceptable fee should be relatively low, with 41% favouring a fee of $10 or less per visit and a further 39% opting for $20 or less.

(f) Postnatal care - Postnatal care was taken up by 97% of the women surveyed and was generally rated highly. The charges payable by users were low especially at non-private facilities. The inclusion of preventive health services in the course of postnatal care given such as cervical pap smear screening was low, although higher than that found in GOP services.

(g) Cost of postnatal care - Expenditure by user on postnatal care was low overall. 76% of those women who received care at MCH centres and government hospitals spent no money on postnatal care. 55% agreed that there should be a fee for postnatal services offered at MCH centres and the most acceptable level of fee was between $1 and $20 per visit.

(h) Family planning - On the basis of the sample referred to in paragraph 5, 88% of women in the child-bearing age group appeared to be using some form of contraception. In this group, condoms (41%) and oral contraceptives (32%) were most popular. Advice was mainly sought from MCH centres (49%), family

planning clinics (19%) and private practice (21%). Convenience, familiarity and confidence, followed by low charges and advice from family and friends, were most commonly given as the reasons for their choice. The declared level of satisfaction was high irrespective of source, although the fees charged varied from source to source. Most (87%) spent less than $100 and 30% spent nothing. 75% of those responded to a question on the charging of fees for family planning services at MCH centres thought that charging a fee would be reasonable; 95% suggested a fee level of between $1 and $20 per visit.

(i) Preventive care for infants - MCH centres were the facility used predominantly for the care of well-babies in Hong Kong. The use of preventive health services was documented for 299 children. Only two (0.6%) of these were not immunized; 90% were immunized at MCH centres. 90% of the children underwent developmental screening, 97% of these at MCH centres. In general, mothers chose MCH centres for convenience and on the recommendation of doctors, nurses and hospitals and less than 10% quoted low charges as a reason. Levels of satisfaction were generally high.

(j) Curative care for infants - About two-thirds (64%) of the children had had a health problem the month before the interview. 94% of these had taken medical advice; most consulted a doctor only once but 14% had consulted four times or more. In contrast to preventive services, the majority sought advice from private doctors and only 6% attended GOP clinics. Only 2% of children did not receive some form of medication in the last consultation; 70% received three or more types of medicine. In addition, 18% of the surveyed children were given medication not prescribed by a medical practitioner in the month before.

(k) Hospitalization - The cumulative hospitalization rate in the sampled children aged six months to three years was 14% for those admitted once, 4% for those admitted twice and 2% for those admitted three times or more. 20% of the surveyed children had been hospitalized at least once.

(l) Health care expenditure - In contrast to health spending in the general population survey where only 38% of respondents spent more than $100, 64% of the parents of sampled children did so.

Conclusions

7. The general standard of MCH care, at least in terms of accessibility, affordability and client satisfaction appears to be high.

8. Government clinics and hospitals, together with subvented hospitals provide most of the care for pregnant mothers; in contrast, most medical attention for infants (most of them suffering from upper respiratory infections) is provided by the private sector. The expenditure on care payable by the majority of respondents is low and although most mothers would accept charges for antenatal, postnatal and family planning services in government facilities, they suggested that this should not exceed $20 per visit.

Survey of the General Population
(Health Problems, Choices of Care and Patterns of Utilization in a Well-Population Telephone Survey)

The Sample

9. In a general health enquiry by telephone of a territory-wide well-population sample of residents, an overall response rate of 79% was obtained. A total of 1 496 respondents were interviewed.

Summary of Major Findings

10. The major findings are summarized below -

(a) "Doctor shopping" - Younger individuals, particularly those aged 20-29 and less than 10 years old (in this case their parents) were most likely to shop for doctors, with the elderly the least likely.

(b) Belief in the "Hot/Cold" (熱氣 / 寒涼) concept - The overall prevalence of belief in the "Hot/Cold" concept was 86%, which compared closely to that (89%) found in the GOP survey.

(c) Compliance - The completion of a course of treatment was related to age, (the elderly

were more likely to complete), educational level (less educated more likely to complete) and marital status (singles more likely to complete).

(d) Self-ratings of health - The majority (95%) rated their health as very good or fair. 28% reported a health problem in the two weeks preceding the interview. Most of these comprised symptoms of respiratory illness, headache, fever and digestive complaints.

(e) Choices and utilization of health care - Of those who had a health problem in the two weeks prior to the interview (417 out of 1 496), 62% sought professional advice either from Western or Chinese practitioners and 15% relied on lay advice. Active self care included the use of over-the-counter drugs (27%), diet (24%), Chinese herbs (13%) or left-over drugs (10%). Of those who saw a doctor, 65% sought private care and 15% used GOP services. Less than 1.5% of those consulting doctors consulted one whose charges were paid by the respondents' employer.

(f) Smoking - The prevalence of smoking was higher in males (28%) compared with females (5.8%), with the elderly having the highest rate (34.4%). In this sample, there were no recorded smokers in the 0-9 year age range, but the cumulative proportion smoking at ages 10-19 years was 5.7%. 80% of respondents had been given advice to quit at some time, but were still smoking.

(g) Hospitalization - About 7% of the respondents had been hospitalized in the past 12 months. The main provider of hospital care was the government system (45%), followed by subvented (32%) and private (23%).

(h) Health care expenditure - Over 62% spent less than $100 on health care (including hospitalization , consultation, medication and tonics) in the three-month period preceding the interview. 30% spent between $100 - $500 during this period of time. Only 8% spent more than $500 on health care. The median expenditure on seeking professional advice from a private doctor

during the past two weeks was HK$80. One in seven of the respondents had health insurance, more prevalent among those with post-secondary education, the employed, and those whose monthly household income exceeded $10,000. Information on the source of premiums was obtained from only 88 respondents who had health insurance and of these, 48% were paid for by employers.

Conclusions

11. The younger and the more educated groups have a pattern of health care utilization characterized by more doctor shopping, less consultations with the same doctor than the elderly and less educated. The elderly and less educated are also more likely to complete courses of physician-prescribed medication. The reasons for this may be that the elderly have less disposable income to spend on health care. Also, their expectations for health care may be lower than those of the younger age groups, so dissatisfaction with consultation may not prompt a change of doctor.

12. This survey has confirmed the findings of the 1989 General Household Survey that the private sector is the main provider of out-patient medical consultations (accounting for 65%) with GOP clinics catering for 15%. In contrast to ambulatory care, the main provider of hospital service is the government and subvented system (77% compared to 23% in private hospitals). As only one-seventh of respondents have health insurance, this finding is not surprising since, without the protection of health insurance, some people who usually receive ambulatory care from private doctors would have to go to public instead of private hospitals because of financial consideration when hospitalization is necessary.

Appendix 4

Summary of Survey on Doctors Working in Government General Out-patient Service and the Family Health Service

Introduction

This opinion survey on doctors working in the GOP Service and the FHS was initiated and conducted by the Department of Health. The objective was to seek the views of doctors on the functions of the services, the training needs, and the facilities and equipment which should be provided for the effective and efficient operation of their respective areas of services. The survey was conducted by way of self-administered questionnaires. These were designed with input from the Government Doctors' Association. Questionnaires were sent to all doctors on 8 December 1989 and completed returns were received in early January 1990. The survey was monitored by a steering group comprising staff of the Department of Health and the Department of Community Medicine and Unit for Behavioural Sciences of the University of Hong Kong, the latter having been commissioned by the Working Party on Primary Health Care to conduct separate surveys.

Summary of Major Findings

Profile of Respondents

2. In the GOP Service, 128 out of a total of 175 doctors working in GOP clinics during the survey period responded, representing a response rate of 73.1%. Over half of them (57%) were aged 45 and above. More than 50% of the doctors had been registered for six years or more. About 48% of the respondents had worked in GOP clinics for six years or more.

3. In the FHS, 51 out of a total of 57 serving doctors in FHS during the survey period responded, representing a response rate of 89.5%. About two-fifths of them (43.1%) were aged 45 and above. Almost half (49.%) of them had been registered for six years or more. About 37% of the respondents had worked in FHS for six years or more.

Functions of GOP Clinics

4. Follow-up management of patients with chronic conditions, providing low-cost service for those in need and treatment of minor ailments were considered by respondents to be the three most important functions of GOP clinics. A smaller percentage of respondents commented that GOP clinics functioned as the source of referral to specialist clinics and centre of surveillance of communicable diseases.

5. In general, about 60% of the doctors commented that the functions of GOP clinics were being met to a very large or reasonably large extent. However, "too many patients to attend to", insufficient facilities and shortage of staff were regarded as the major factors hindering the functioning of GOP clinics.

Functions of FHS

6. A majority of respondents considered prevention of childhood infectious diseases, provision of family planning service and provision of antenatal care to be the three most important functions of FHS. Other existing services provided by FHS such as screening of developmental defects in children and health education were also considered to be very important.

7. In general, about 90% of the doctors commented that the functions of FHS were being met to a very large or reasonably large extent.

8. Insufficient manpower and heavy workload and to a lesser extent, lack of professional training were considered by the doctors as the main factors hindering the functioning of FHS.

Sector of Population to be Served

9. About 65% of the doctors in GOP clinics thought that the GOP clinics should cater for the whole population while 50% of the respondents supported the idea that GOP clinics should cater for those who required subsidized service. The opinion of FHS doctors on the question differed from GOP doctors. About 84% of the respondents thought that the whole women and children population should be catered for by the FHS while only 28% of the respondents supported that FHS should cater for those who required subsidized service.

Medical Records

10. About half of the GOP doctors who commented on the existing medical record system in GOP clinics said that it was satisfactory. Over half of the doctors preferred the records to be kept by doctors while only about 15% of the respondents preferred the patients to keep their own records. About 86% of the doctors in FHS commented that the existing medical record system in FHS was satisfactory.

Drugs and Equipment

11. Among the GOP respondents, 63% considered the existing formulary to be inadequate. Some 42% of the doctors agreed that medication should be given to patients for every consultation. About 45% of the doctors regarded the existing provision of medical equipment as adequate. Some 52.5% of the respondents favoured the installation of ECG machine.

12. In the FHS, about 52% of the respondents regarded the existing medical equipment to be adequate. About 35% of the doctors thought that the existing formulary was not adequate.

Consultation Time

13. On the whole, GOP doctors preferred an average consultation time of 5.5 minutes per patient as compared with the current average of about 3.3 minutes per patient. In the FHS, the preferred average consultation times for different types of service (such as family planning, antenatal/postnatal and infant care) ranged from 6.9 to 8.3 minutes per patient when the current average consultation time was 5.7 to 6.4 minutes.

Investigations and Referrals

14. A small proportion of doctors in GOP clinics said that they had experienced problems in ordering simple radiological examinations (11.7%) and pathology tests (10.9%) for their patients. Most doctors in FHS said they had not experienced problems in arranging simple radiological examinations and pathology tests for their patients but about one-third of the doctors sometimes encountered problems in arranging ultrasonograms.

Re-distribution of Duties

15. About 60% of the GOP doctors who had responded to the question of re-distribution of duties among various grades of clinic staff in GOP clinics did not believe that this could improve the service at all. On the other hand, 64.4% of the FHS doctors said that such could improve the service.

Choice of Doctors in GOP clinics

16. Two-thirds of the doctors in GOP clinics did not prefer patients who came for the first time to have a choice of doctors while a similar proportion thought that patients should be allowed to see the same doctor in their follow-up visits.

Training

17. Virtually all GOP doctors (127 out of 128) responding to the survey said that training was required. Refresher course was preferred by 79.5% while 65.4% were in favour of a structured programme leading to a higher qualification. About half favoured education in the form of teaching pamphlets/notes and audio/visual cassettes. Clearly, a considerable proportion was in favour of all the different forms of training.

18. All respondents in FHS said that training was required and their pattern of preference for the different forms of training was similar to their GOP colleagues.

Satisfaction towards Work

19. About two-thirds (64.6%) of the doctors in GOP clinics were very satisfied/satisfied with their present work. Personal preference and interest (43.8%) and regular hours (29.5%) were quoted as the reasons for choosing to work in GOP clinics.

20. Likewise, two-thirds (66%) of the doctors in FHS were very satisfied/satisfied with their present work. Doctors in FHS said that they worked in FHS because the work was interesting or they were familiar with the work (45.7%) or because of regular hours (41.3%).

Appendix 5

Membership of the Delegation Visiting Singapore

Professor Rosie T T YOUNG, OBE, JP (Leader)

Secretary for Health and Welfare
Mrs Elizabeth WONG, ISO, JP

Professor S P B DONNAN

Professor John C Y LEONG

Dr Christopher D ADAMSON-LUND

Dr Peter C Y LEE, LLD, JP

Mr Donald CHIA

Mrs Alice CHONG

Miss Mona LO

Mr YEUNG Po-kwan, OBE, CPM, JP

Dr S H LEE, ISO, JP

Dr Lawrence F M LAI, JP

Mrs Carrie LAM

Mr G F WOODHEAD (Secretary)

Appendix 6

Institutions in Singapore Visited by the Delegation

Ministry of Health

Macpherson Outpatient Department

Toa Payoh Polyclinic

Toa Payoh Senior Citizens' Health Care Centre

School Health Clinics at the School Health Service, Institute of Health

Observation of the work of a School Health Team in a primary school

Training and Health Education Department

Health Corporation of Singapore

National University Hospital

Singapore General Hospital

Faculty of Medicine, National University of Singapore

College of General Practitioners, Singapore

Appendix 7

Membership of the Sub-groups

Statistics Sub-group

Convenor Professor Rosie T T YOUNG, OBE, JP

Members Professor S P B DONNAN

Miss Mona LO

Dr Natalis C L YUEN, JP

Dr K H PANG, JP

Mrs Carrie LAM

* Professor A J HEDLEY,
Department of Community Medicine
University of Hong Kong

* Professor D WATSON,
Department of Community & Family Medicine
The Chinese University of Hong Kong

* Mrs Edwina SHUNG,
Senior Statistician,
Department of Health

* Miss Lilian FUNG,
Senior Statistician,
Hospital Services Department

Secretary Mr G F WOODHEAD

Clinic Services Sub-group

Convenor Professor Rosie T T YOUNG, OBE, JP

Members Professor John C Y LEONG

Professor S P B DONNAN (until 12.05.90)
Professor P C LEUNG (from 13.05.90)

Dr Anthony NG

Dr Peter C Y LEE, LLD, JP

Mr Donald CHIA

Dr S H LEE, ISO, JP

Mr Brian BRESNIHAN

Mrs Carrie LAM

* Professor A J HEDLEY
Department of Community Medicine
University of Hong Kong
(for meetings discussing general out-patient clinics)

* Professor D WATSON
Department of Community & Family Medicine
The Chinese University of Hong Kong
(for the meeting discussing training for primary care doctors)

* Dr Clarke MUNRO
Department of Medicine
University of Hong Kong
(for the meeting discussing training for primary care doctors)

Secretary: Mr G F WOODHEAD (until 31.05.90)
Ms Annie CHOI (from 01.06.90)

School Health Services Sub-Group

Convenor: Mr YEUNG Po-kwan, OBE, CPM, JP

Members: Dr Natalis C L YUEN, JP

Mr G F WOODHEAD

* Ms Nancy CHUNG
Headmistress, Kei Wan Primary School

* Dr CHAN Nang-fong
  Senior Lecturer in Community Medicine
  The Chinese University of Hong Kong

* Dr Margaret CHAN
  Assistant Director of Health
  (Personal Health Services)

Secretary Miss Dora NG
  Senior Executive Officer
  (Health & Welfare) Medical 1

Community Services Sub-group

Convenor Mrs Alice CHONG

Members Ms Mona LO

Ms Moyna WONG

Dr Lawrence F M LAI, JP

Mrs Carrie LAM

* Mr Alfred CHUI
  Assistant Director of Social Welfare
  (Family Welfare)

* Dr W M CHAN
  Assistant Director of Health
  (Health Administration and Planning)

* Dr H FUNG
  Principal Medical and Health Officer
  (Services and Manpower, Development and Planning), Hospital Services Department

* A representative from the Welfare Division of the Health and Welfare Branch

Secretary Mr Alexander CHAU
  Senior Executive Officer
  (Health and Welfare) (Medical)2

Health Promotion and Disease Prevention Sub-group

Convenor Dr K H PANG, JP

Members Dr C D ADAMSON-LUND

Miss Mona LO

Mr G F WOODHEAD (until 31.05.1990)
Ms Annie CHOI (from 01.06.1990)

* Professor A J HEDLEY
Department of Community Medicine
University of Hong Kong

* Dr S Y CHAN
Occupational Health Consultant
Labour Department

* Dr W I HO
Community Physician (Kowloon)
Department of Health

* Dr K H MAK
Senior Medical Officer
(Epidemiology, Health Research & Statistics)
Department of Health

* Dr L Y TSE
Senior Medical Officer
(Family Health Services)
Department of Health

* Dr W L CHAN
Senior Medical Officer (Special Duties),
Department of Health

* Dr Constance CHAN
Medical Officer in-charge
(Central Health Education Unit)
Department of Health

* Dr Philip HO
Medical Officer
(Central Health Education Unit)
Department of Health

* Mrs Edwina SHUNG
Senior Statistician
Department of Health

Secretary Miss Dora NG

Co-ordinating Sub-group

Convenor Professor Rosie T T YOUNG, OBE, JP

Members Professor P C LEUNG

Dr Anthony NG

Mr Donald CHIA

Mrs Alice CHONG

Mr YEUNG Po-kwan, OBE, CPM, JP

Dr S H LEE, ISO, JP

Dr K H PANG, JP

Mrs Carrie LAM

Ms Annie CHOI

Secretary Miss Dora NG

* Denotes co-opted members

Appendix 8

Proposed Health Education Strategy

The proposed health education strategy should be based on the following -

(a) to identify principal issues and targets for health promotion and disease prevention through research and evaluation of data;

(b) to emphasize in health promotion the large preventable fraction of the common causes of serious morbidity and premature deaths in Hong Kong and to promote self-care;

(c) to translate well established epidemiological findings into effective health promotion practice;

(d) to draw on scientific data to disseminate convincing health messages to the public and to counter misinformation from commercial interests on health inducive and destructive factors;

(e) to identify differences between social and demographic groups and their inequalities in health and access to health promotion influences;

(f) to identify through studies of population groups the impact of social and environmental changes upon them and specific health interventions;

(g) to identify overall health goals in the community and factors pertaining to the achievement of these goals;

(h) to set up standing committees or working groups to study specific problems such as trends in morbidity and mortality and specific targets for intervention and to promote community involvement to develop public interest in health; and

(i) to develop an efficient health information system for easy access by the health care professionals as well as the public and to enhance the system by computerization.

Appendix 9

Existing Immunization Schedule

Vaccine	Disease	Schedule	Remarks
BCG	Tuberculosis	At birth	To provide immunity to young infants.
		Primary school children (after Mantoux testing)	To maintain immunity among at-risk children.
Type 1 Oral Polio	Poliomyelitis	At birth	To provide immunity against type 1 polio which is a paralytic strain.
DPT Triple Vaccine	Diphtheria Pertussis Tetanus	3 doses at 2, 3, 4 months at 4 weeks interval	To provide immunity against pertussis, diphtheria and tetanus at an early age.
		Booster at 1-1/2 years	To maintain immunity in toddlers.
Trivalent Oral Polio	Poliomyelitis	2 doses at 2 & 4 months at 8 weeks interval	To provide immunity against all 3 types of polio virus.
		Booster dose at 1-1/2 years, primary 1 & primary 6	To maintain immunity among toddlers and school children.
DT Combined Vaccine	Diphtheria Tetanus	Primary 1 & 6	To maintain immunity against diphtheria and tetanus among school children.
MMR	Measles Mumps Rubella	1 year	To provide immunity against measles, mumps and rubella.
Rubella	Rubella	Primary 6 school girls	To provide immunity to teenage girls so as to prevent Congenital Rubella Syndrome.
Hepatitis B	Hepatitis B	3 doses at birth, 1 month and 3-5 months	To provide sustained immunity against hepatitis B.
	HBIG	At birth for babies born to HBsAg positive mothers	To provide additional protection for at risk infants.

Appendix 10

Notification of Communicable Diseases in Hong Kong 1984-1989 by Age Groups

Age \ Year	Diphtheria						Pertussis (Whooping Cough)					
	1984	1985	1986	1987	1988	1989	1984	1985	1986	1987	1988	1989
0	–	–	–	–	–	–	14	16	1	–	6	4
1 – 4	–	–	–	–	–	–	2	3	–	–	1	–
5 – 9	–	–	–	–	–	–	2	2	–	–	1	–
10 – 14	–	–	–	–	–	–	–	–	–	–	–	–
15 – 44	–	–	–	–	–	–	–	–	–	–	–	–
45 – 64	–	–	–	–	–	–	–	–	–	–	–	–
65 & over	–	–	–	–	–	–	–	–	–	–	–	–
Total	–	–	–	–	–	–	18	21	1	–	8	4

Age \ Year	Tetanus (incl neonatorum)						Measles					
	1984	1985	1986	1987	1988	1989	1984	1985	1986	1987	1988	1989
0	–	–	1	1	–	–	174	90	67	51	601	23
1 – 4	–	–	–	–	–	–	281	109	67	48	723	59
5 – 9	–	–	–	–	–	–	172	49	48	66	848	38
10 – 14	–	–	–	–	1	–	38	15	15	24	669	10
15 – 44	25	9	12	3	2	3	9	11	16	5	306	9
45 – 64	18	19	19	4	6	1	–	1	1	–	–	–
65 & over	3	3	1	–	1	1	–	–	–	–	–	–
Unknown	–	–	–	–	–	–	4	5	1	–	15	–
Total	46 (29)	31 (23)	33 (19)	8 (4)	10 (4)	5 (3)	678 (2)	280 (1)	215	194 (1)	3162 (8)	139 (1)

Age \ Year	Poliomyelitis						Tuberculosis					
	1984	1985	1986	1987	1988	1989	1984	1985	1986	1987	1988	1989
0	–	–	–	–	–	–	7	2	2	6	5	1
1 – 4	–	–	–	–	–	–	54	39	44	42	40	46
5 – 9	–	–	–	–	–	–	49	35	32	51	31	34
10 – 14	–	1	–	–	–	–	80	90	65	58	69	69
15 – 44	–	–	–	–	–	–	4370	4069	3854	3754	3555	3345
45 – 64	–	–	–	–	–	–	2130	2148	2060	1949	1909	1839
65 & over	–	–	–	–	–	–	1147	1158	1356	1385	1412	1366
Unknown	–	–	–	–	–	–	6	4	19	24	–	4
Total	–	1	–	–	–	–	7843 (420)	7545 (409)	7432 (407)	7269 (405)	7021 (388)	6704 (403)

Note : Figure in brackets denotes deaths

Appendix 11

Mortality Data in Hong Kong, 1988

	For the age group 15-44 (1988)	For the age group 45-64 (1988)
a) Population	3 million (52% of total population)	1 million (18% of total population)
b) Total no. of deaths	2 001 (67.8/100 000)	6 784 (675.2/100 000)
c) Major causes of death		
(i) Malignant neoplasm	704 (23.9/100 000)	3 047 (303.3/100 000)
-liver and intrahepatic bile ducts	122 (4.14/100 000)	485 (48.3/100 000)
-trachea, bronchus and lung	68 (2.31/100 000)	798 (79.4/100 000)
-esophagus and stomach	45 (1.5/100 000)	351 (34.9/100 000)
-nasopharynx	114 (3.86/100 000)	241 (24.0/100 000)
-female breast	31 (2.18/100 000)	115 (24.4/100 000)
-cervix uteri	14 (0.99/100 000)	52 (11.0/100 000)
(ii) -Injury and poisoning	664 (22.5/100 000)	375 (37.3/100 000)
(iii) -Heart disease	139 (4.7/100 000)	922 (91.8/100 000)
-acute myocardial infarction	37 (1.25/100 000)	369 (36.7/100 000)
-chronic rhematic	15 (0.51/100 000)	62 (6.17/100 000)
-disease of pulmonary circulation	13 (0.44/100 000)	80 (7.96/100 000)
-hypertensive heart disease	8 (0.27/100 000)	159 (15.8/100 000)
-other ischemic heart disease	7 (0.24/100 000)	150 (14.9/100 000)
d) Diabetes Mellitus	6 (0.2/100 000)	38 (3.78/100 000)

For All Ages

(a) 30% of total death are neoplasms.
(b) 29% of total death are circulatory system diseases.
(c) 17.5% of total death are respiratory system diseases.

Appendix 12

Number of Students Enrolled in the School Medical Service

Academic Year	No. of Enrolments	No. of Eligible Students	Enrolment Rate (%)
1985/86	349 064	792 742	44.03
1986/87	369 035	796 944	46.31
1987/88	380 166	800 326	47.50
1988/89	428 307	798 754	53.62
1989/90	367 546	792 708	46.37
1990/91	352 429	785 300*	44.88

* This is the enrolment forecast figure

Appendix 13

Public Expenditure on the School Medical Service

Financial Year	Administrative Unit of SMS	Capitation Grant	Total Provision
	HK'000	HK$'000	HK$'000
1985/86	624	22,555	23,179
1986/87	708	23,352	24,060
1987/88	720	24,370	25,090
1988/89	1,248	25,643	26,891
1989/90	1,433	32,669	34,102
1990/91	1,322	40,178	41,500

Appendix 14

The School Health Service in Singapore

The School Health Service in Singapore is run by the Primary Health Division of Ministry of Health. It provides preventive and promotive health services to nearly half a million school children in Primary, Secondary, special schools and Pre-U Colleges. This is basically a health service rather than a medical service. For medical service, students go to government clinics (where they are charged at half the adult rate) or to private practitioners at their own expense. Medical treatment will be provided by the School Health Service only if the child is actually ill when being examined. In the primary schools all health activities are performed by the visiting school health teams; in the secondary schools students are encouraged to participate in the health activities. Full scale examination of students are given when they enter and leave primary schools and towards the end of secondary schools. All students are given periodical examination. Back-up services are available at the School Health Service Headquarters at the Service's Institute of Health, which provides general and specialist clinic service covering a wide range of health problems and other support services. The specialist clinic sessions are often staffed by visiting specialists from hospitals and universities. These include ophthalmic clinics, nutrition/obesity clinics, spinal/scoliosis clinics, audiometry/otology clinics, a cardiac clinic, an endocrine clinic, an adolescent clinic and a learning disorders clinic.

2. To implement the school-based programmes, Singapore is divided into six zones each served by a health team of one medical officer, one nursing officer, six staff nurses, three assistant nurses, three clerks and one driver doing the examination for the school children in that zone at each school. A lap-top computer is provided for each team for the entry of the health records of individual student. These records are then fed into the main computer in the headquarters. Apart from medical screening and health education, an important function of the team is to complete the immunization schedule for each child. For this purpose the data from the Central Immunization Registry is transferred to the School Health Service computer frame for children when they enter primary school. The data

is cross-matched with school enrolments and is available to the field health teams for updating. Defaulters are thus able to be followed up quickly.

3. If the screening throws up significant problems the nurse will refer the student to the doctor in the team who may then refer the child to the general or specialist clinics at the School Health Service Headquarters. Observation and management is performed at these clinics free of charge; if a severe problem is encountered the case will be referred to a specialist out-patient clinic or hospital for treatment at normal cost. Observations on the child are recorded in his personal health book, which together with the immunization data, provides continuity of care between the Maternal and Child Health Clinics and the School Health Service.

4. The service is also supported by a Research Unit which conducts various research programmes to establish the state of health of Singapore school children and to determine and evaluate methods for the management and control of common health problems of school children. Intensive formalized in-service training programmes are organized for staff to upgrade their knowledge, clinical, communication and administrative skills to cope with changing needs of the SHS.

Appendix 15

Student Health Service -
School-Based Programme for Primary Schools

	Primary 1	Primary 2/3	Primary 4/5	Primary 6
ME/SE	ME by Doctor	SE by Nurse	SE by Nurse	ME by Doctor
Screening Programme	.Ht/Wt/ Nutritional Status/Ht/Wt Percentiles/ Vision/ Colour Vision/ Audiometry/ Speech .Phy/Emot/ Ment/Soc/ Educ Assessment	.Ht/Wt/ Nutritional Status/Ht/Wt Percentiles/ Vision .Update health problems (previous & current)	.Vision .Update health problems (previous & current)	.Ht/Wt/ Nutritional Status/Ht/Wt Percentiles/ Vision .Phy/Emot/ Ment/Soc/ Educ Assessment
Immuni-zation	.Booster Diphtheria/ Tetanus .Booster oral polio .Immunization check & update accordingly	.Update Immunization for defaulters	-	.Booster Diphtheria/ Tetanus .Booster oral polio. .Rubella
Health Education	.Pamphlets on SHS/Healthy Lifestyles/ Eye Care/ Self-care .Personalized talks by Doctors on Healthy Lifestyles .Orientation Day Briefings by SHS	.Distribution of pamphlets & posters on Healthy Lifestyles/Growth & Development/ Eye Care/Smoking/Drug abuse/Self-care for common problems .Ad hoc Health Talks/Video Presentation/ Discussions/Question & Answer Sessions on above topics & any other topical subjects		
Documen-tation	.Record in medical records for SHS .Record in Health Booklets for parents reference	.Record in medical records for SHS		.Record in medical records for SHS .Update on Health Booklets for parents

Appendix 15
(continued)

Student Health Service – School-Based Programme for Secondary Schools

	Secondary 1/2	Secondary 3	Secondary 4-7
ME/SE	SE by Nurse	ME by Doctor	SE by Nurse
Screening Programme	.Vision .Update health problems (previous & current)	.Ht/Wt/Nutritional Status/Ht/Wt Percentiles/ Vision/Blood Pressure .Pubertal Staging .Phy/Emot/Ment/Soc/ Educ Assessment	.Vision .Update health problems
Health Education	.Distribution of pamphlets and posters on Healthy Lifestyles/Growth & Development/Eye Care/Smoking/Drug Abuse/STD/AIDS .Ad hoc Health Talks/Video Presentation/ Discussions/ Question & Answer Sessions on above topics and any other topical subjects	.Special talks, Question and Answer Sessions on Breast Self-Examination by nurse and on STD/AIDS/Cervix Cancer by doctor in addition to all above.	
Documentation	.Record in medical records for SHS	.Record in medical records for SHS .Update on Health Booklets for parents	.Record in medical records for SHS

Key

ME = Medical examination
SE = Screening and evaluation
Ht = Height
Wt = Weight
SHS = Student Health Service
STD = Sexually Transmitted Diseases
AIDS = Acquired Immune Deficiency Syndrome

Phy = Physical
Emot = Emotional
Ment = Mental
Soc = Social
Educ = Educational

Appendix 16

Arrangements to Strengthen the Co-ordination between the Out-patient Clinics and the Hospitals Recommended by the Provisional Hospital Authority

(a) Co-ordination between the general out-patient service and hospital services should be enhanced and improved, e.g. referral of out-patients should be made to the specialist clinics which have the shortest waiting times through an information feedback system.

(b) Multi-disciplinary training for doctors in out-patient clinics is desirable, and could be provided by attaching these doctors to various specialties in hospitals and vice versa.

(c) The utilization of general out-patient clinics should be increased, e.g. by providing a 24-hour service at selected clinics so that patients can attend them instead of going to Accident and Emergency Departments in the hospitals. In addition, general out-patient clinics could be provided close to Accident and Emergency Departments.

(d) At present, general out-patient clinics only perform a very limited range of minor operations such as the removal of cysts and circumcision, nor do they have facilities for patient observation. In order to reduce the need for hospital attendance, "day beds" should be introduced in the general out-patient clinics to enable the conditions of patients whose need for hospital admission cannot be ascertained in the first instance to be observed. The list of minor operations and medical procedures that can be carried out at the general out-patient clinics should be examined, with a view to expanding it so as to reduce the pressure on the Accident and Emergency Departments and hospital admissions.

(e) There should be a close link between accident and emergency medicine and primary health care and there are grounds for expanding the ambulatory care function in Accident and Emergency Departments, in particular to cater for cases received outside the normal working hours of general out-patient clinics. The increased use of observation beds in Accident and Emergency Departments should also be considered.

Source : Report of the Provisional Hospital Authority December 1989, pages 129-130.

Appendix 17

Views of the Working Group on Review of Community Nursing Service on the Organization of CNS as a Community-based Service

The Working Group acknowledged the need to enhance the role of CNS and considered that much of the problems related to inadequate medical and paramedical support could in fact be solved with the development of primary health care centres with the family physician playing the role of a primary health care team co-ordinator. Thus, the Working Group considered it most appropriate for CNS to be organized and integrated with other health services, and be developed as a truly community-based service organized with other health services under the Department of Health.

2. The Working Group, however, expressed the following concerns about the pace of implementation and other practical issues related to such a re-organization at the operational level -

(a) historically, most organizations now providing CNS are subvented hospitals which provide both professional and administrative back-up support to the service;

(b) upon establishment of the Hospital Authority, all community nurses now working in subvented hospitals will become Hospital Authority staff;

(c) despite an increased emphasis on the health aspects, it is expected that hospital-discharged patients will continue to contribute to a large portion of patients in CNS; and

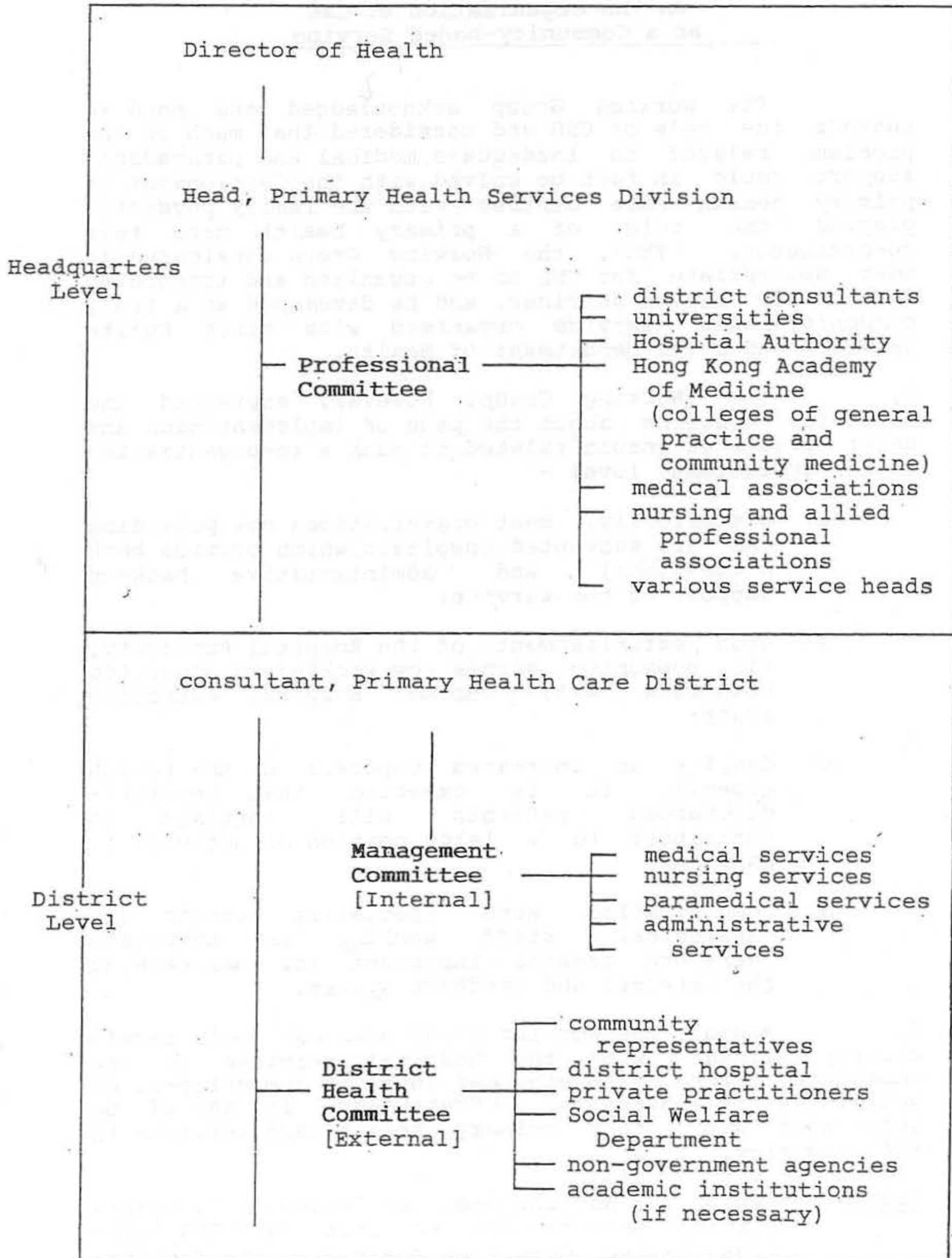
(d) communication with specialist doctors and paramedical staff working in hospitals therefore remains important for maintaining the referral and feedback system.

3. Hence, the Working Group sees CNS would remain closely linked with the hospital services in the immediate future. An enhanced level of community-based activities is desirable. Eventually, it should be integrated with other primary health care services in the community.

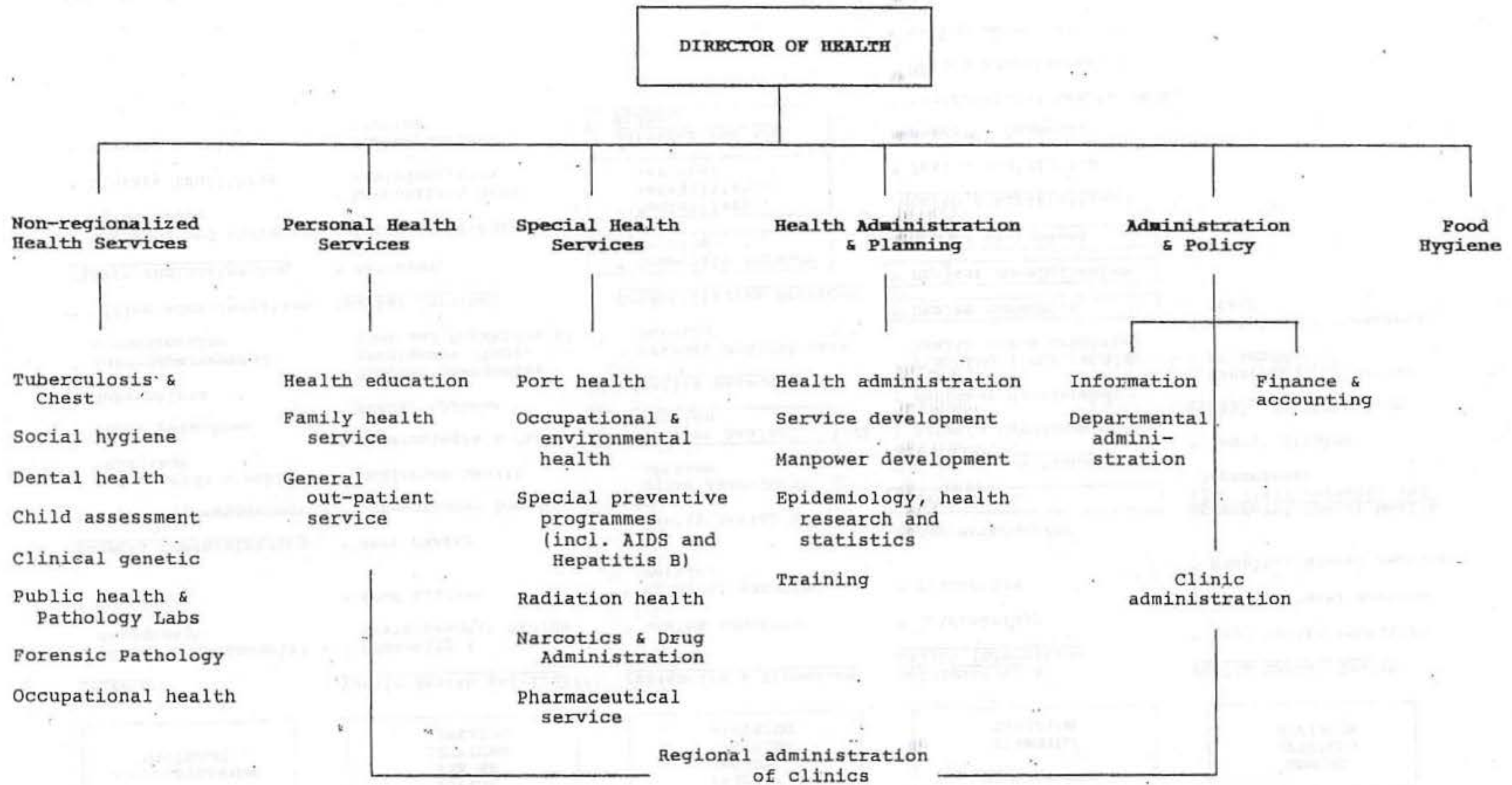
Source : Report of Working Group on Review of Community Nursing Service set up under the CNS Joint Consultative Committee chaired by the Hospital Services Department.

Appendix 18

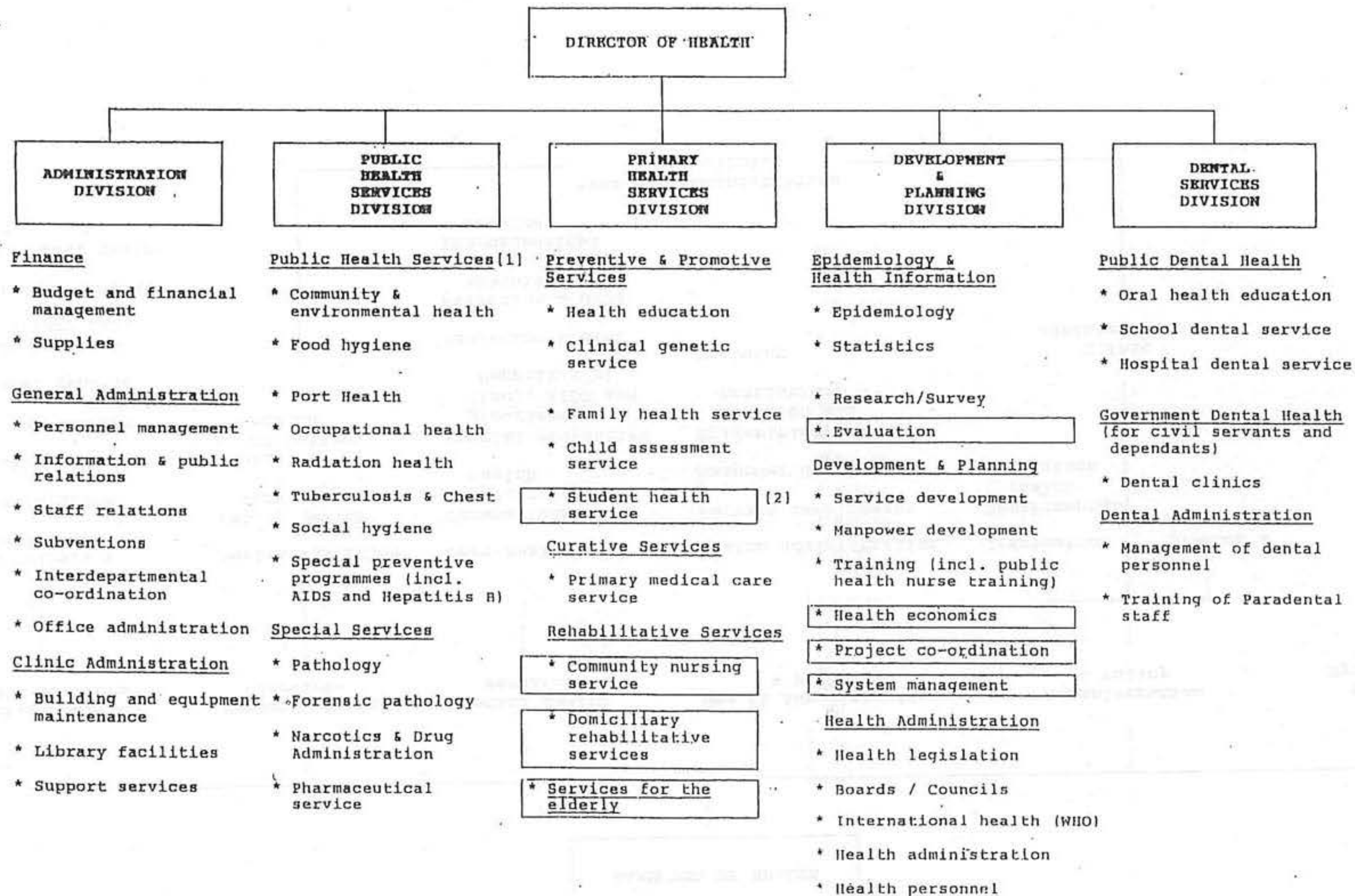
The District Health System



PRESENT ORGANIZATION OF THE DEPARTMENT OF HEALTH



PROPOSED RE-ORGANIZATION OF THE DEPARTMENT OF HEALTH



[1] These public health services also contribute to the preventive and promotive aspects of primary health care and despite the organizational set-up, there is an absolute need for close co-ordination between the two divisions.

[2] The service in boxes represents new service units recommended by this Working Party.

Appendix 21

Estimated Proportion of Target-group and Non-target-group Users Among Current GOP Users

Using the Department of Health's records and findings of the HKU GOP Survey, the frequency of usage of the GOP service by the respective target groups is estimated as follows -

Target Group	Proportion of GOP Consultations
Young children aged 0 to 18	22%
The elderly aged 65 and above	22%
Public Assistance recipients	1% *
Disability Allowances recipients	1% **

Notes : * The 1% is derived from the actual number of cases seen at GOP clinics with their fees waived as a percentage of the total number of cases in 1989 (39 596 out of 4 010 873 cases seen by doctors). As some 67% of PA recipients as at 31.3.90 were elderly over 60, a considerable proportion of this 1% will have already been covered under the elderly target group which is estimated to account for 22%.

** The 1% for the disabled is purely an estimate based on the number of people receiving the Disability Allowance or the Higher Disability Allowance at 1989 and assuming that their usage of GOP service resembles their proportion in the general population. In 1989, about 62 000 people were in receipt of disability allowances, or say roughly 1% of the population. Again, there is likely to be a considerable portion of double-counting between the disabled target group and the elderly and young target groups.

One major limitation to the estimate is the use of GOP service at no charge by civil servants, retired civil servants and their eligible dependants which accounted for some 19.4% of all consultations in 1989 of whom there is no available age profile. If our proposal for separate accounting arrangements for the provision of such services to civil servants is adopted, this would help to provide a much clearer picture.

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