For discussion on
4 August 2023

Paper FC 8/2023

Family Council

Primary Healthcare Blueprint

PURPOSE

This paper briefs Members on the Primary Healthcare Blueprint ("the Blueprint") released by the Health Bureau.

BACKGROUND

2. To strengthen Hong Kong's primary healthcare system, the Government released the Blueprint on 19 December 2022 setting out a series of reform initiatives to formulate the direction and strategies of primary healthcare development in view of the challenges brought about by an ageing population and the increasing prevalence of chronic disease. Through prevention-oriented, community-based and family-centric strategies which focus on early detection and intervention, our vision is to improve the overall health status of the population, provide accessible and coherent healthcare services, and establish a sustainable healthcare system. Full text and pamphlet of the Blueprint are available at the Health Bureau's thematic website (www.primaryhealthcare.gov.hk).

3. One of the key recommendations under the Blueprint is to enhance the community-based primary healthcare system. The Government will launch the Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) from 2023 to provide targeted subsidies to citizens for early diagnosis and management of target chronic diseases through self-selected family doctors in the private healthcare service sector to address the increasing chronic disease prevalence particularly hypertension (HT) and diabetes mellitus (DM).

4. According to the Report of Hong Kong Population Health Survey 2020-22[1] released by the Department of Health, around 37% and 41% of patients with DM and HT, respectively, were unaware of their condition prior to the health examination. Through CDCC Pilot Scheme, citizens would be able to receive screening, monitoring and intervention as early as possible in order to prevent occurrence of chronic diseases or related complications.

5. The community-based healthcare consists of "family doctor for all" concept and various district-based services. Through family doctors in the private sector, the CDCC Pilot Scheme will identify people with high risk of HT and DM early. The scheme will provide evidence-based screening service and subsidised treatment package for persons with prediabetes, DM and HT in order to provide timely intervention and prevent complications that would otherwise arise from the delayed diagnosis of the chronic diseases. Through the assistance of District Health Centre (DHC)/DHC Express, participants could select and be matched with a family doctor listed in the Primary Care Directory, in order to foster continuous and holistic primary care.

6. A brief introduction on the Blueprint and CDCC Pilot Scheme are set out in the Powerpoint presentation materials at **Annex I and II** respectively.

ADVICE SOUGHT

7. Members are invited to note the content of the presentation and provide comments.

Health Bureau
August 2023

[1] Health examination formed a part of the survey.

Annex I

基層醫療健康藍圖
Primary Healthcare Blueprint

中華人民共和國香港特別行政區政府
醫務衞生局
Health Bureau
The Government of the Hong Kong Special Administrative Region of the People's Republic of China

基層醫療健康藍圖
Primary Healthcare Blueprint

1. 背景
   Background
2. 甚麼是基層醫療?
   What is primary healthcare?
3. 基層醫療健康藍圖
   Primary Healthcare Blueprint
4. 結論
   Conclusion

香港: 人口老化 、慢性疾病越趨普及

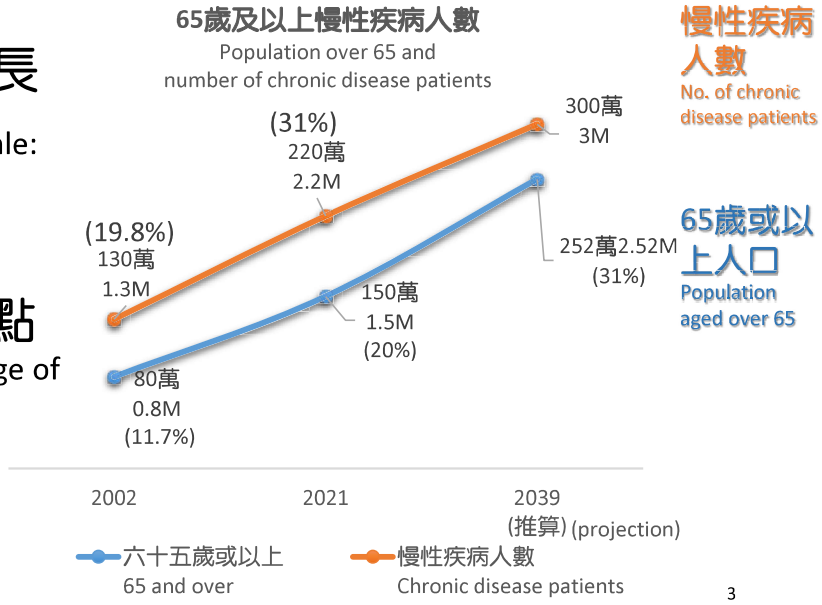
Ageing Population & Increasing Chronic Diseases Prevalence in Hong Kong

- 平均壽命 男: 83.4 女: 87.7 全球最長

  Longest life expectancy (Male: 83.4 / female: 87.7) in the world

- 人口年齡每增加五年，慢性疾病比例增加10百分點

  Every 5 years of increase in age, percentage of chronic diseases increases by 10%

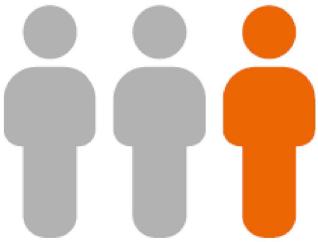


醫療系統可持續性：糖尿病及高血壓

Sustainability of Healthcare System：Diabetes Mellitus and Hypertension

約一半
為隱性

About half are undiagnosed



每三個
有一個
患併發症

One in three has developed complications

併發症
醫療成本
高兩倍

Service cost for complications is two times higher

醫療系統可持續性
Sustainability of Healthcare System

市民面對的健康挑戰
Health challenges faced by citizens

不掌握自己健康狀況	年紀漸長體質轉差	慢性疾病風險增加	擔心經常出入醫院
Uncertain about my health condition	Health declines as I get old	Higher risks of chronic diseases	Worry of frequent trips to hospitals

基層醫療是什麼?

What is primary healthcare?

- ✓ 服務七百萬
  Serves 7 million
- ✓ 預防勝治療
  Prevention beats cure
- ✓ 小病在社區
  Treat mild cases in the community
- ✓ 一人一醫生
  Family doctor for all
- ✓ 一站式治理
  One-stop care
- ✓ 一人一病歷
  Personalised health record for everyone
- ✓ 家門口跟進
  Follow up at the doorstep

- ✗ 只照顧基層
  Care for grassroots only
- ✗ 大病先求醫
  Seek medical care only when situation worsens
- ✗ 小病睇專科
  Visit specialists for mild diseases
- ✗ 病急亂求醫
  Clueless of where to seek medical help
- ✗ 出入醫院頻
  Frequent visits to hospitals
- ✗ 病歷通處存
  Health record scattered everywhere
- ✗ 覆診排長龍
  Long queues for follow up

基層醫療健康藍圖: 願景及策略

Primary Healthcare Blueprint: Vision & Strategies

願景 Vision

改善市民整體健康狀況
Improve the overall health of the population

提供連貫全面醫療服務
Provide continuous and comprehensive healthcare services

建立可持續的醫療系統
Create a sustainable healthcare system

策略 Strategies

- 以預防為重 Prevention-centric
- 以社區為本 Community-based
- 以家庭為中心 Family-centric
- 早發現早治理 Early detection & intervention

基層醫療健康藍圖: 重點方向

Primary Healthcare Blueprint : Major areas

5

重點方向

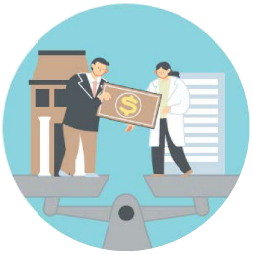
Major areas

建立系統

Develop a Community-based System

加強管理

Strengthen Governance



善用資源

Consolidate Resources

規劃人手

Reinforce Manpower

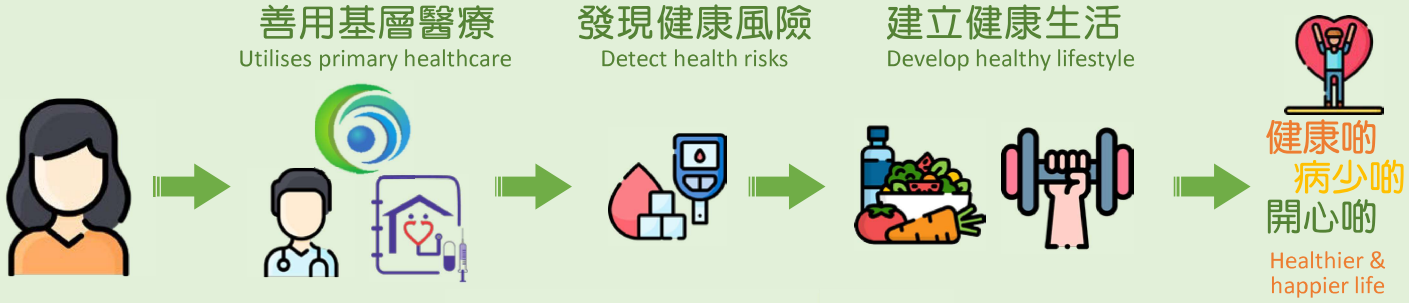
整合數據

Improve Data Connectivity and Surveillance

善用基層醫療
Utilises primary healthcare

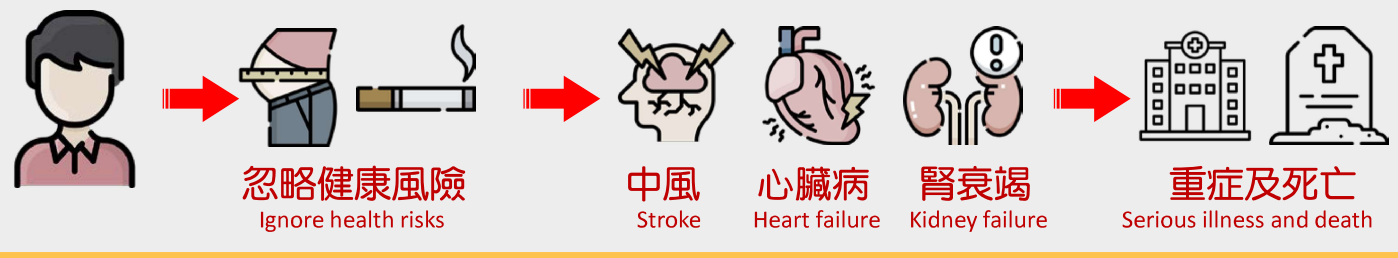
發現健康風險
Detect health risks

建立健康生活
Develop healthy lifestyle



你想做邊個?

Who would you rather become?

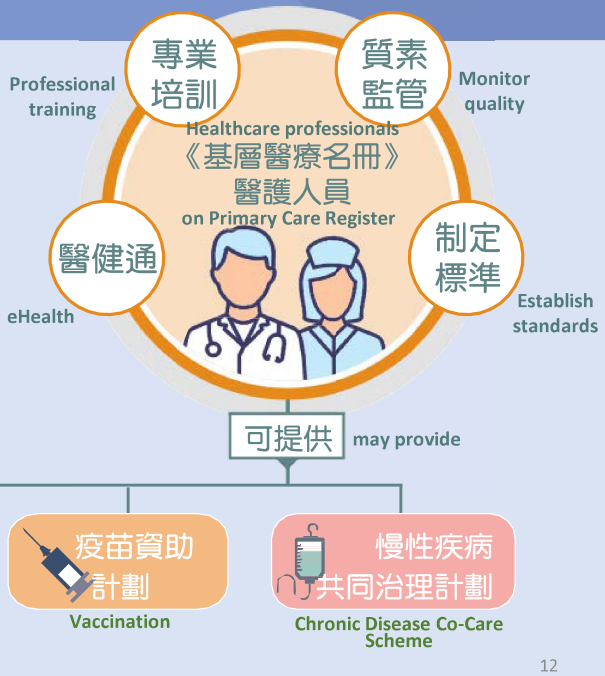


預防勝治療
Early detection, timely intervention

- 我可以在地區康健中心得到健康資訊及治理服務
  I can receive health information and treatment at District Health Centres
- 政府資助我篩查和管理高血壓及糖尿病
  The Government subsidises and arranges me to screen and manage hypertention and diabetes
- 公營醫療系統仍然是我的安全網
  The public healthcare system continues to be my safety net

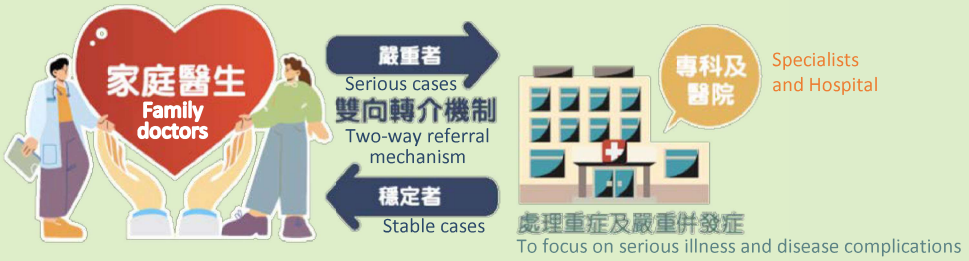
一人一醫生
Family Doctor for all

- 我有自選的家庭醫生
  I have a self-selected family doctor
- 長期跟進並了解我的健康需要
  Continuous follow up and knows my health needs best
- 《基層醫療名冊》保證質素
  Care quality is ensured by the Primary Care Register



小病在社區
Treat mild cases in the community

- 我可以在社區透過家庭醫生控制慢性疾病
  I could manage chronic disease with my family doctor in the community
- 我能夠在病情嚴重時獲得需要的專科及醫院服務
  I may receive the required specialist and hospital services when my situation worsens
- 病情穩定後，家庭醫生繼續監察和跟進
  My family doctor continues to monitor and follow up on my situation after it stablises



一站式治理
One-stop care

- **我能夠在社區得到專業的共同護理**
  I shall receive professional care in the community in a collaborative manner
- **由地區康健中心統籌服務**
  Services to be co-ordinated by District Health Centres

一人一病歷
Personalised health record for everyone

- 我擁有個人的電子健康紀錄戶口
  I own my personal electronic health record account
- 我和我的醫護人員能夠全面了解我的病歷
  My care team and I will all be able to understand my medical history thoroughly
- 醫健通用科技幫助我監察和管理健康
  I can monitor and manage my health situation through the use of technology with the assistance of eHealth

預防勝治療
Early detection, timely intervention

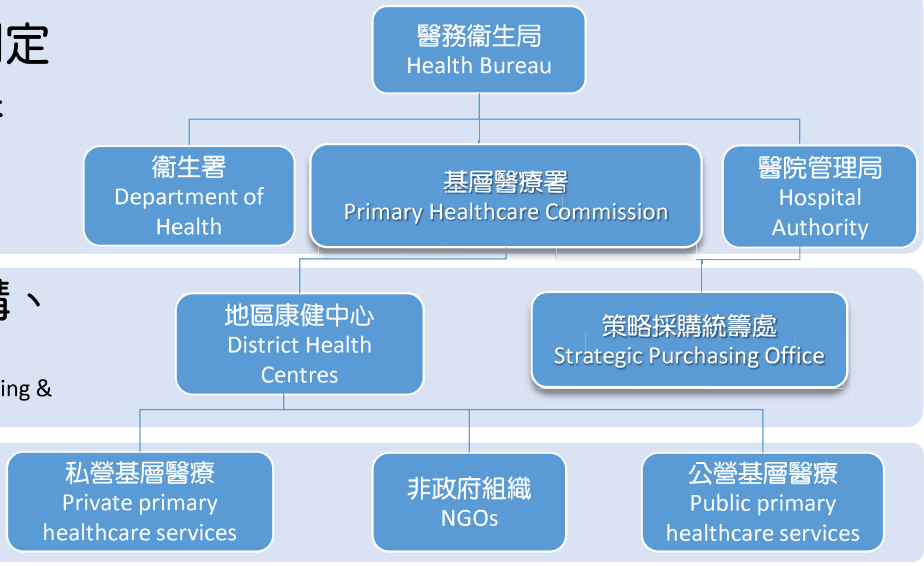
- 我可以善用部分醫療券金額用做評估、疾病篩查和控制等特定用途
  I can use a portion of vouchers and meaningfully on health assessment, disease screening and management

加強基層醫療管理
Strengthen primary healthcare governance

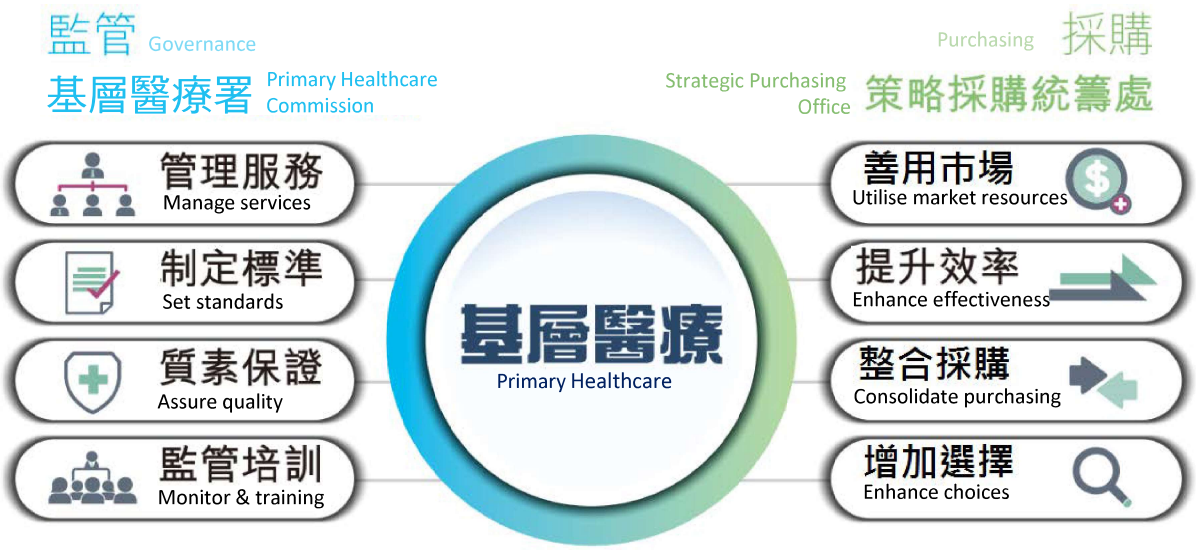
決策、分配資源、制定標準、監察健康效果
Decision making, resource allocation, standard setting & surveillance of health outcome

協調服務、策略採購、監察表現
Service co-ordination, strategic purchasing & performance monitoring

提供服務
Service provision



基層醫療署及策略採購統籌處
Primary Healthcare Commission and Strategic Purchasing Office



健康啲 病少啲 開心啲

Healthier and Happier Life

預防勝於治療

An ounce of prevention
is worth a pound of cure

健康管理由年輕做起

Health management
starts young

早發現 早治理

Early detection
timely intervention

及早投資健康
減省未來開支

Invest in health
savings in future

多謝 Thank you

Annex II

慢性疾病共同治理先導計劃（共同治理計劃）
Chronic Disease Co-Care Pilot Scheme (CDCC Scheme)

彭飛舟醫生
Dr. PANG FEI CHAU

基層醫療健康專員
Commissioner for Primary Healthcare

中華人民共和國香港特別行政區政府
醫務衞生局
Health Bureau
The Government of the Hong Kong Special Administrative Region of the People's Republic of China

背景
Background

2022年10月17日
17 Oct 2022

《2022年施政報告》
Policy Address 2022

制定政策方向以推出
慢病共治計劃
Set out the policy direction to launch the CDCC Scheme

2022年12月19日
19 Dec 2022

《基層醫療健康藍圖》
Primary Healthcare Blueprint

為強化本港的基層醫療健康系統
制定發展方向及策略
Set out direction of development and strategies for strengthening Hong Kong's primary healthcare system

2023年7月17日
17 Jul 2023

共同治理計劃
CDCC Pilot Scheme

自公布《基層醫療健康藍圖》以來，
首個推動基層醫療的項目
The first item to promote primary healthcare since the announcement of "Primary Healthcare Blueprint"

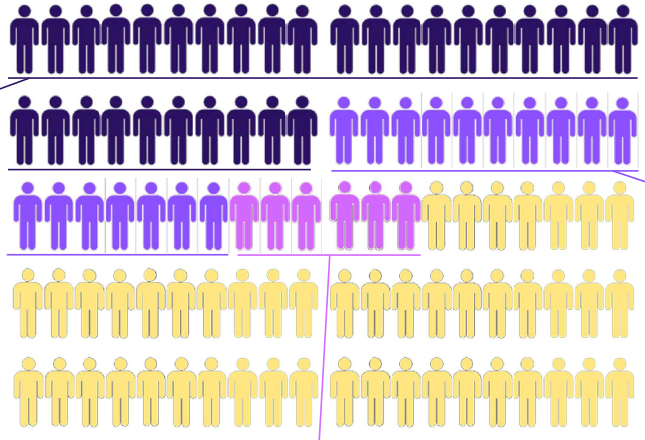
「每個人都是自己健康的第一責任人」

"Everyone is the first person responsible for his/her health"

共同治理計劃就是實踐這個理念，
強化每位市民去負責自己健康的能力和意識，
醫護團隊就在市民身邊扶持他們去關顧自己的健康。
CDCC Scheme is designed to put this concept into practice,
by strengthening each citizen's ability and awareness of
taking responsibility for his/her own health.
Medical team is there to support citizens to take care of their own health.

香港45歲或以上的人口中
Among Hong Kong population aged 45 or above

每100個人…
In every 100 people...



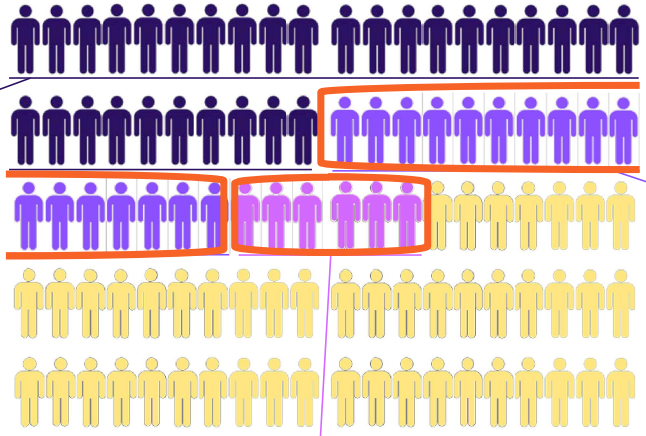
30個
確診患有糖尿病或高血壓
Diagnosed with diabetes or hypertension

17個
未有察覺自己其實已經患上糖尿病或高血壓
Unaware of the fact that he/she has diabetes or hypertension

6個
有血糖偏高的情況
High blood sugar levels

香港45歲或以上的人口中
Among Hong Kong population aged 45 or above

每100個人…
In every 100 people...



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Unaware of the fact that he/she has diabetes or hypertension

6個
有血糖偏高的情況
High blood sugar levels

共同治理計劃希望找出這兩類型人士
CDCC Scheme aims to identify these two types of individuals

共同治理計劃
CDCC Scheme

登記報名篩查
Enrollment for Screening/GP

45歲或以上人士可以到地區康健中心*登記報名篩查。地區康健中心會為市民作初步健康評估。

Individuals aged 45 or above can enroll for screening at the District Health Centres (DHCs). DHCs will conduct initial health assessment for the participants.

配對家庭醫生
Family Doctor Matching

地區康健中心會按市民自己的選擇為他配對及預約家庭醫生問診和安排抽血檢驗。

DHCs will help participants to conduct family doctor matching according to their own choices, make appointment for consultation, and arrange blood tests.

繳付診金
Consultation Fee

市民只需付診金120元，化驗費用就由政府承擔，市民無需額外付款予化驗所。

Each participant only needs to pay a consultation fee of $120, while the laboratory fee will be borne by the government. Participants do not need to pay additional fees to the laboratory.

長期跟進
Long-Term Follow up

若市民被診斷為高血壓、糖尿病或血糖偏高，醫生和地區康健中心會提供自我健康管理、風險評估、藥物治療、飲食體重管控方案和健康人生計劃的疾病預防建議。

If participants are diagnosed with high blood pressure, diabetes or high blood sugar, doctors and DHCs will provide advice on self-management, risk assessment, drug treatment, diet and weight control programmes, and life course preventive care programme.

*由2024年第一季起，醫生配對和篩查可以直接在醫生的診所內進行
Family doctor matching and screening can be carried out directly at doctor clinics since 2024/1Q

共付費用一覽 (草擬中)
Subsidy & Co-payment Summary (Indicative)

醫療券 Health Care Voucher
長者醫療券(包括指定用途) 適用於此計劃*
Elderly Healthcare Vouchers (including Designated Use) are applicable to this scheme*

WAIVER
醫療費用減免 不適用於此計劃
Medical Expense Waiver is NOT applicable

服務提供者 Service Provider	服務範圍 Service Scope	政府資助額 Government Subsidy	參加者共付額 Participants Co-Pay Amount
醫生 Family Doctor	篩查診症 Screening Consultation	$192(一次性) $192 (one-off)	**劃一為$120 (一次性)** $120 (one-off)
	治療診症 Treatment Consultation	$162 (per subsidised visit)	**醫生所訂明的共付額 (每次資助診症)** (可高於/等於/低於政府建議的參考共付額: $150) Doctor decides co-pay level with price transparency to facilitate patient choice (Publicized reference co-pay price: $150)
	治療藥物處方 Drug	$103.5 per quarter	**毋須額外付費** (包括基本藥物，如控制糖尿病和血壓的藥物及執業家庭醫生常用的偶發性疾病藥物) No additional co-pay for drugs within basic tier of Scheme Drug List
醫務化驗所 Laboratory	篩查期間的化驗及檢查 Screening investigation according to Scheme	✓ (100%)	**毋須額外付費** No additional co-pay
	治療期間的化驗及檢查 Treatment investigation according to Scheme	✓ (部分) (partial, per item)	**逐項收取共付額** Co-pay per item within Scheme Investigation Items
護士診所及專職醫療 Nurse Clinic & Allied Health	護士診所診症 Nurse Clinic (Consultation)	✓ (部分) (partial, per subsidised visit)	**待定** To be announced
	專職醫療服務節數 (視光師/ 足病診療師/ 營養師/ 物理治療師) Allied Health Session (Include Optometrist/ Podiatrist/ Dietitian/ Physiotherapies)	✓ (部分) (partial, per subsidised visit)	**待定** To be announced
地區康健中心 District Health Centre	健康管理小組 Health Management	✓ (100%)	**免費** Free

推行時間表
Launch Timeline

2023 年第四季
2023/4Q

第一階段
1st Phase

- 參加者可於地區康健中心進行報名及醫生配對
  Participants can enroll and matach with family doctors at the DHCs

第二階段
2nd Phase

- 家庭醫生配對和篩查更可以直接在醫生診所內進行
  Family doctor matching and screening can be carried out directly at doctor clinics

2024 年第一季
2024/1Q

鞏固基層醫療發展必須具備的7件事

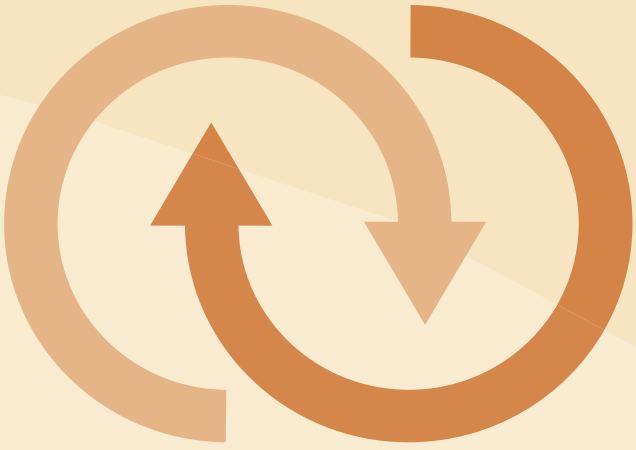
7 Elements to Strengthen Primary Healthcare Development

與醫管局協定的雙向轉介機制

Protocol-driven Bi-directional Referral Mechanism with HA

參加者經家庭醫生評估後，若有臨床需要，會按照已訂立的轉介標準和指引，獲轉介去七個聯網指定的診症服務。這個只是一次性的專科診症服務

After being assessed by the family doctor, participant with certain clinical conditions will be referred to the 7 Clusters under HA for designated specialist consultation, in accordance with the established referral criteria and protocols. The speci alist consultation is on a one-off basis



在制定護理計劃後，病人就會被轉介回到他原來的家庭醫生繼續跟進

After a care plan is developed, the patient will be referred back to his original family doctor for follow-up

需尋求內科醫療諮詢的情況
Conditions required M&G specialist consultation

- 糖尿病、高血壓**控制不理想**
  Suboptimal disease control on DM/ HT
- 出現**新的併發症**
  New complications arising
- 患者病情**惡化**
  Deterioration of patients' conditions

醫患夥伴達標獎勵
Incentive for Doctors and Patients

旨在鼓勵病人積極參與治療過程，並遵循私家醫生建議，以**達到治療目標**，並**提升健康水平**
It aims to o encourage patient empowerment and to drive the achievement of desirable patient health clinical outcome

所有符合要求的病人(診斷為高血壓及血糖偏高 / 高血壓及糖尿病 / 高血壓 / 糖尿病)，在進入治療階段後都會**自動納入達標獎勵計劃**

All eligible patients (diagnosed with high blood pressure & high blood sugar / high blood pressure & diabetes / high blood pressure / diabetes) will **automatically enroll in the incentive mechanism** after entering the treatment phrase

達標獎勵將從病人的第二個個人計劃年度開始計算 (即**病人進入治療階段的日期起計12個月後**)

The incentive mechanism will start from the second Participant Programme Year onwards for each established doctor-patient relationship (i.e. **12 months after the date the patient entered the treatment phase**)

在**達標後**的下一個個人計劃年度開始時，病人的第一次**受資助診症共付額**將**最高獲扣減**政府建議的參考共付額($150)

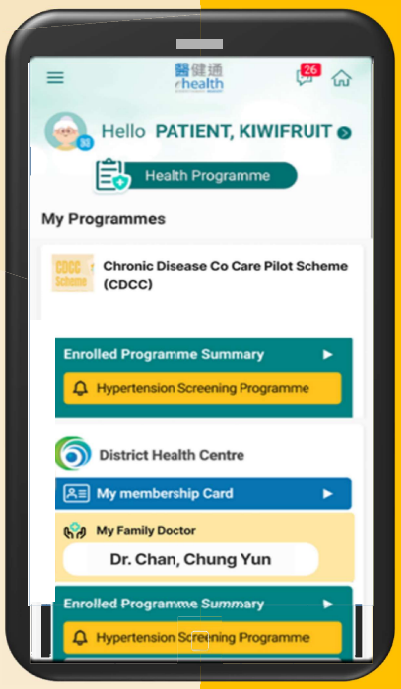
At the beginning of the next Participant Programme Year **after reaching the target**, the patient's first **subsidized consultation copayment** will be **reduced by up to** the government's recommended reference copayment (**$150**)

社區藥物名冊
Community Drug Formulary

- 策略採購統籌處會透過中央採購，讓參加政府資助計劃的醫生**以一個相當優惠的價錢**，向醫院管理局的藥物供應商**購買社區藥物名冊下的藥物**
  Doctors participating in government-subsidized programmes will be enabled to **purchase drugs under the Community Drug Formulary at favourable prices** from the drug suppliers of HA, via central procurement by the Strategic Purchasing Office (SPO)
- 在共同治理計劃中，基本藥物已包括一般使用於計劃中慢性疾病，及偶發性疾病的藥物（例如：用於傷風感冒的藥物）
  Basic medications include those generally used for the indicated chronic diseases in the CDCC Scheme as well as medication for episodic illnesses (e.g. common cold, flu or cough etc.)
- 政府亦會向有為病人提供慢性疾病藥物的醫生提供資助，資助額是每一位病人每季約103.5元，而市民不需額外付費
  The government will also provide subsidies to doctors who provide patients with chronic disease drugs. The subsidy amount is about $103.5 per patient per quarter, and the public does not need to pay extra

醫健通
E-Health

- 參加慢病共治計劃的醫生及參加者均需**同意加入「醫健通」**
  CDCC doctors and participants shall agree to **join eHealth**
- 並同意與醫健通相關服務提供者共享資料
  And agree to share data with eHealth related service providers

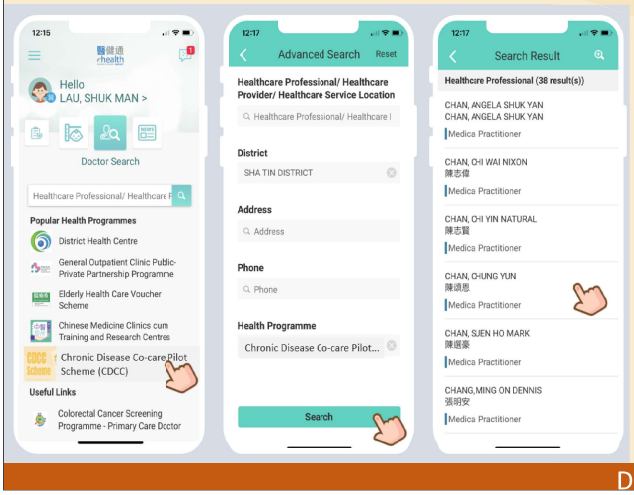


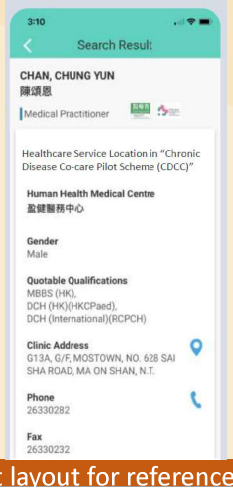
政府會藉此機會逐步更新資訊科技系統，支援治療流程，相關功能包括：
The government will take this opportunity to gradually update the IT system to support the treatment process. Related functions include:

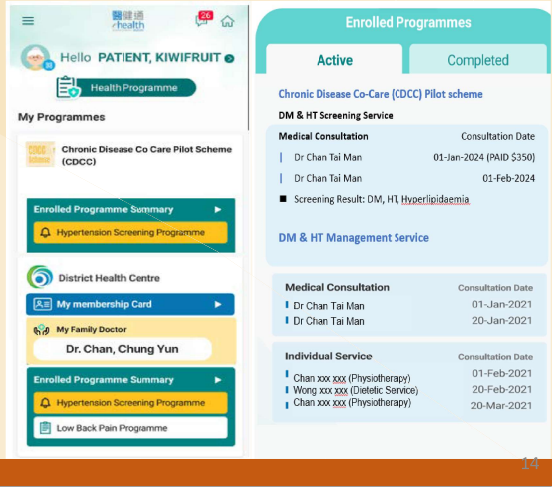
- 報名
  Enrolment
- 與家庭醫生配對
  Family Doctor matching
- 供家庭醫生作臨床記錄（包括評估、查看篩查結果以作診斷、臨床紀錄、健康人生計劃）
  Clinical Documentation (including assessment, screening result (diagnosis), clinical notes, life course preventive care)

醫健通
E-Health

- 搜尋家庭醫生
  Search for family doctor
  - 搜尋慢病共治計劃中的家庭醫生
    Search for CDCC family doctor
- 顯示家庭醫生資料
  Show Family Doctors' Profile
  - 名字
    Name
  - 聯絡方法
    Contact Information
- 慢病共治計劃中之參加者資料
  CDCC Participation information
  - 診症記錄
    Medical records
  - 共付額
    Co-pay amount







謝謝

Thank you