Chapter 3 – Reforms to the Health Care Delivery System

The Challenge

13. The current life expectancy at birth is 77 years for men and 82 years for women. At present, about 11% of Hong Kong's population of 6.7 million are at 65 or above. It is projected this percentage will increase to 15% by 2019. To promote health and minimise disability among older persons , many preventive health programmes, medical interventions and rehabilitative services are required.

14. Hong Kong has experienced its epidemiological transition from communicable to chronic diseases. Chronic illnesses rank high in our burden of diseases and disabilities. These illnesses require long term management, which is labour and technology intensive and generally expensive, and the illness may significantly affect patients' quality of life.

15. Into the new millennium, one of the main challenges to our health care system is to develop a framework for providing health care services which can minimise and best manage the prevalence of chronic diseases and burden of disability, and promote health and wellness. Against this background, this chapter looks into the issues in the existing delivery system and proposes some directions for change.

Objective

16. The fundamental role of a health care system is to enhance the health of the population and improve the community's quality of life. To ensure that our health care delivery system can fulfil this role, we need to protect the health of the population, prevent disease and disability, promote lifelong wellness and provide treatment, care and rehabilitation to the sick, injured and disabled. We seek to improve the health outcome and cost efficiency of the system through the development of a community-focused, patient-centred and knowledge-based health care system, comprising an appropriate balance of preventive, ambulatory, in-patient and community outreach services,

delivered in a humane way over an individual's lifetime, supported by sustained collaboration among health care providers, and between the latter and the community.

Strategic Directions

17. To achieve our objective, we propose to pursue the following strategic directions :-

(a) Strengthen preventive care;
(b) Re-organise primary medical care;
(c) Develop a community-focused, patient-centred and knowledge-based integrated health care service;
(d) Improve public/private interface;
(e) Facilitate dental care; and
(f) Promote Chinese medicine

Strengthen Preventive Care

18. Preventive care is the science and art of preventing disease, promoting and protecting health and improving the quality of life through organised community efforts. Effective preventive care has a significant impact on the health care needs of the community. It reduces the incidence of disease, both communicable and non-communicable, enhances the health status of the population and lowers the overall burden of disease and disability of the community.

19. Maintaining good health is a personal responsibility and any effort to prevent diseases needs to involve the individual. Taking ownership of one's own health, an individual should make appropriate plans on how to avoid illness and disability and remain healthy. Many infections, illnesses, diseases and disabilities are preventable, or at least, their effects ameliorated through self-care efforts.

20. In preventive care, one key role of Government is to provide the necessary information, encouragement and infrastructure to enable people to control and improve their health. This infrastructure includes not only the structure and processes for health and patient education but also the wider knowledge and understanding of the health impact of socio-economic decisions . A key responsibility of Government is to oversee the development of preventive care, identify and assess the impact of social and environmental variables to health, protect health through legislation and regulations, provide services ranging from disease

surveillance and prevention, health education and promotion, to immunisation and health screening.

Proposal

21. In spite of the good work already performed, there are still ways to strengthen the effectiveness of preventive care to achieve greater health gains. We propose that the Department of Health should adopt the role of an advocate for health, working in concert with the Health and Welfare Bureau, seeking political commitment, policy and systems support and social acceptance for different health goals and programmes. The Government will address the full range of potentially modifiable determinants of health – not only those related to individuals, such as health behaviours and lifestyles, but also factors external to the traditional health domain. Significant health gains may be achieved by managing the health impact of the wider social, physical and economic environments of the community.

22. We propose that Government should build up an intersectoral infrastructure, covering all related sectors, including health care, education, environment and others, to focus and collaborate on preventive health issues. Together with Government, the parties concerned would identify and set priorities for health, formulate health targets, plan and develop strategies and monitor their implementation. It will be easier to gain influence over the determinants of health through such joint efforts.

23. We propose that the Department of Health must seek to continuously enhance community involvement in health education and promotion activities. These efforts will strengthen, at the personal level, the capability and commitment to prevent diseases, the knowledge and understanding to improve health and the ability to make decisions on treatment processes; and at the community level, the influence to create living conditions conducive to health. A high level of continuous public participation sustains health promotion efforts, provides social support to health issues and helps address related conflicts within the community.

Implementation

24. The Department of Health will, commencing from 2001-02, prepare for and phase in various new initiatives devised in accordance with the directions described above. The efforts will be supported by appropriate staff training, outside consultancy help and development of performance indicators. We expect the Department to develop, by end- 2002, a long term plan for strengthening preventive care as proposed.

25. As a start, based on its monitoring of the health trends in Hong Kong, the Department aims to commence preparing, in two years' time, regular reports on the health status of the community. In parallel, the Department will carry out health impact assessment of socio-economic variables and different environmental problems. These efforts will form the basis to

support the formulation of health priorities, targets and strategies.

26. The Department of Health will review its health promotion strategies and capacity, provide training to enhance skill in health promotion, expand intersectoral collaboration, build up an alliance for health and actively solicit community participation and support. The Department will develop evaluation tools to measure the effectiveness of health education and promotion efforts.

Re-organise Primary Medical Care

27. People will still get sick in spite of preventive care, and when that happens, normally their first point of contact is with primary medical care practitioners. Primary care practitioners are engaged in preventive care and provide continuing care and medical treatment to patients and refer them to specialised care where necessary. Effectively carried out, the functions of the primary care practitioners can help reduce significantly the pressure on secondary and tertiary care and the overall health care expenditure of the community.

28. We believe that the effectiveness of primary medical care can be gradually enhanced by the promotion and adoption of family medicine practice and the development of other primary care practitioners, including other physicians, nurses and allied health professionals. Family medicine is a specialised discipline

of medicine that provides primary, continuing and comprehensive care to an individual and the family in their own environment. The care is holistic, incorporating the interaction and inter-relatedness of psycho-social and physical elements of health. In Hong Kong, the development of this specialty is still at an early stage. There are currently only about 120 qualified family medicine specialists, and the benefit of family medicine is still not widely known and appreciated. The role of other physicians as primary care practitioners also needs to be examined. The development of the role of nurses and other allied health professionals, such as pharmacists, as primary care providers is also not well recognised and deserves greater emphasis.

29. At present, primary medical care is predominantly provided by general practitioners in the private sector. Patients prefer to consult private practitioners because :-

(a) the private sector allows choice of doctors and offers more flexible consultation hours. The service is more easily accessible than that in the public sector; and

(b) the fees charged by the general practitioners, in the order of $150 per consultation, are generally affordable by the public and regarded as good value.

30. The Department of Health currently operates 65 general out-patient clinics, charging a low fee of $37 per attendance. About 35% of the patients are elders at 65 or above. At unit cost of $219 per attendance, the general out-patient service is highly subsidised. This marked price difference between the public

and the private sectors has generated huge demand for the Department of Health's clinic services. The huge workload has made it difficult for the quality of service to be upgraded.

Proposal

31. To improve primary medical care, we propose that the public sector should take the lead in promoting family medicine practice by doctors, nurses and allied health professionals and provide the relevant training opportunities. The Hospital Authority has started its family medicine training programme since 1997-98, and set up family medicine-based clinics to assist the specialist out-patient clinics by attending to patients in stabilised conditions. These clinics also serve as training ground for health care professionals. The Hospital Authority plans to provide training to a total of 316 family medicine trainees in 2001-02, and in the longer term, about half of the doctors recruited to the public sector will be trained in family medicine and primary care. The Hospital Authority has also been developing the role of nurses as primary care practitioners for long term care in the community.

32. We propose that the Department of Health's general out-patient service should be transferred to the Hospital Authority to facilitate integration of the primary and secondary levels of care in the public sector. At present, there is regular liaison between the two organisations on the referrals to and from the Hospital Authority's specialist out-patient clinics, and shared care programmes, such as those for diabetic patients, have been implemented, but because of the different environments in which

the staff have to work, there remains interfacing problems that need to be addressed.

33. We propose that upon transfer, the general out-patient service should be redesigned into clinics attending to, primarily, the financially vulnerable and those chronically ill, who are exposed to high financial risk because of the long term treatment required. These clinics can also serve as the training ground for family medicine and other models of primary medical care, such as general medical practice, and for other primary care professionals.

34. We propose that the public sector should explore ways to improve collaboration with the private sector, to assist family medicine trainees to complete their training, and to improve on the quality and continuity of care. This objective can be achieved, for example, by contracting out some of the general out-patient services to private practitioners for the purpose of training in family medicine and establishing a network between public and private sectors to support exchange of information and knowledge in primary medical care.

35. We propose that all health care professionals, in the public as well private sectors, should be required to undertake continuing professional education and development which helps maintain and upgrade their standard of service. This proposal will be discussed further in Chapter 4.

Implementation

36. We shall work out, by the end of 2001 –

(a) an implementation plan for transferring general out-patient service from the Department of Health to the Hospital Authority;

(b) the improvement plans for the general out-patient service, including gradual adoption of family medicine practice and training of health care professionals in primary care; and

(c) some initial proposals for collaborating with the private sector in the provision of primary medical care.

Subject to finalisation of these plans and proposals, and consultation with the staff and other relevant parties, we shall seek to implement these initiatives, incrementally, from 2002 onwards.

Develop a Community-focused, Patient-centred and Knowledge-based Integrated Health Care Service

37. With the establishment of the Hospital Authority in 1990, followed by the implementation of the hospital management reforms, public hospital services have significantly improved over the years in terms of quality, cost-effectiveness and efficiency. Supported by its modern day management, development of clinical protocols, pursuit of clinical audits, experience in risk

management and comprehensive information systems, services in the Hospital Authority have become a possible source of benchmarking for the overall health sector.

38. Because of the long term care needs of the chronically ill, and a better understanding of the inter-relatedness of the psycho-social and physical elements of health and illness, international trend has been to focus on the development of ambulatory and community care programmes and to replace, where appropriate, in-patient treatment by ambulatory and out-patient services. This has been made possible following advances in medical technology and changing perspectives of policy makers, providers and users, supported by appropriate training of staff and patients. For example, some of the on-going medical care required by patients with chronic renal disease, including the process of haemodialysis, which is usually offered in hospitals, can now be carried out in clinics on self-service basis with minimum assistance from the health care professionals. For better off patients who can afford the equipment, they can carry out the process of haemodialysis even at home. Locally, we have also proceeded along this route and the Hospital Authority has in recent years stepped up its developments on day surgery, day care, community nursing, outreach programmes, home care and others.

39. Initiatives have been made by the Hospital Authority to develop a patient-centred health service, which recognises the vital role of the individual both as recipient and participant of health care, with better understanding of the psycho-social elements of health and illness and increasing appreciation of the

need for continuity of health care over an individual's lifetime. New models of delivering health care need to be created and new skills to be learnt by health professionals to further develop this attribute.

40. Health care services are evolving both in breadth and in depth, with better appreciation of socio-economic and environmental factors and psycho-social variables which influence health. The knowledge needed for delivering health services has incorporated environmental, social and behavioural sciences. The organisation and provision of health care has become increasingly complex, and skills in managing and organising also need to be learnt and developed in order to provide effective care. Medical science technology is advancing rapidly, with knowledge and understanding evolving so rapidly that systems for knowledge management and application are vital. These systems include continuing education of health professionals, development of research-based clinical practices (evidence-based medicine) and adoption of tools such as clinical practice guidelines which incorporate research evidence. Substantial efforts have been made in developing the systems for knowledge management and application in the Hospital Authority.

Proposal

41. We support this new trend to emphasise less on in-patient services and to develop, in addition to and in partnership with the hospital system, a network of community-based integrated health care services. Care delivered in or around people's home, or in

homely settings in the community, helps maximise the patient's quality of life. The target is to shorten, as much as appropriate, the length of stay in hospitals but to continue the treatment and care in the community. Hospitals are expensive to construct, and complex and costly to maintain and operate. Well designed ambulatory and community care programmes also have the added benefits of achieving greater cost-effectiveness.

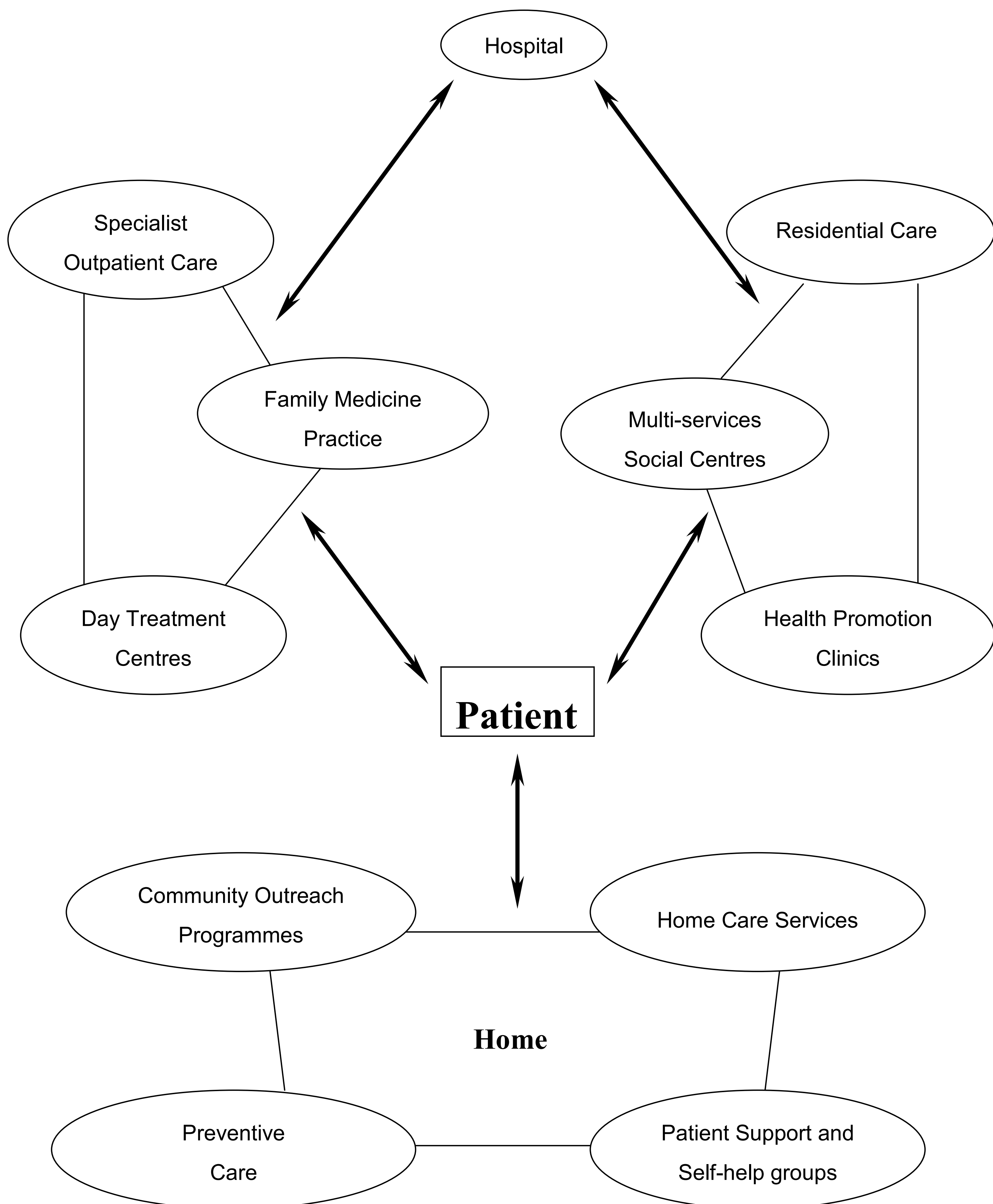
42. We propose that this community-based model should adopt a multi-disciplinary (i.e. joining the efforts of different health care experts and professionals) and multi-sectoral (i.e. joining the efforts of providers in the public and private sectors as well as providers outside the health care sector, particularly the welfare sector and community groups) approach in order to provide a comprehensive and integrated health care service to the patients. A multi-disciplinary approach links up various parts of the delivery system, ensuring that patients obtain the best care from the most appropriate professional staff. A multi-sectoral approach extends the link to outside the health care sectors, ensuring continuity of care for patients and avoiding unnecessary duplication of services.

43. To facilitate the development of community-based services, we are taking steps to revamp the funding mechanism for public health care provision. The allocation of public funding should move away from being input- or facility-based. Instead, it should be based on population needs and specific programmes aiming to enhance health outcomes and the quality of life of people or patients while living in the community. We would encourage the mobilisation of resources from institutions to

community settings with enhancements to the training and provision of community-based teams and workers to support the provision of community-based health care delivery. In the long run, we hope to reduce the over-emphasis on institutional care.

44. Physicians in family medicine and in primary care, in partnership with nurses and allied health professionals, play a leading role in a community-based health care model. They are partners to hospitals by providing treatment and care to patients in the community and helping them with prevention and self-care efforts. The welfare sector is an important ally by extending the care process to cover long term care and social needs. Upon discharge from hospitals, some patients, while in stabilised conditions, but because of their infirmities, require residential care, or from time to time, respite service. Patients staying at home in better health conditions who require assistance with activities of daily living would benefit from services provided in day care centres and by home care teams. With the combined support from the medical and welfare sectors and the community, patients and families, including frail elders and the chronically ill, can continue to enjoy a good quality of life despite their medical conditions. We will facilitate the development of collaborative programmes among various health care and welfare service providers to provide mutual support and shared care. The development of an electronic Health Information Infrastructure (see paragraph 53 below) will help link up all relevant providers in a community network to facilitate their communication and provision of care in continuity. A diagrammatic illustration of this community-based integrated health care service is set out at below.

Community-Based Integrated Health Care Model



45. We propose that continuing professional training and development be required for all health care professionals to enable them to meet the requirements of knowledge-based and patient-centred health services. This proposal will be further discussed in Chapter 4. The Hospital Authority will also work with other health care providers and professional bodies to develop knowledge-management tools such as evidence-based clinical practices.

Implementation

46. We would finalise, for the 2001-02 estimates, a new funding formula for the Hospital Authority based on population and demographic profiles rather than on the number of hospital beds as at present. This will remove one major barrier to the development of community-based service. Providers will no longer be deterred from developing care programmes not directly linked to beds or facilities.

47. The Hospital Authority would formulate, by end-2001, an outline plan for the development of this community-based integrated health care service. The plan would include proposals on different community care programmes, targets to be achieved and evaluation tools to measure the effectiveness of these programmes. The process will be a dynamic one, and the model will take time to evolve.

48. The Hospital Authority would also work out, by end-2001, a plan for the future development of knowledge-based health services.

Improve Public/Private Interface

49. The lack of effective interface and collaboration among health care providers, in particular between the public and the private sectors, has been a main concern. It causes discontinuity of care, unnecessary duplication of services and abortive expenses. It restricts the choice of providers by patients. Some patients find themselves entrapped within a particular sector, if not within a particular institution or provider. This lack of an effective interface has led to the present rather uneven distribution of workload between the public and the private sectors. Both the medical professionals and patients would like to see improvements in this area.

50. There are several barriers giving rise to the lack of effective interface between the public and private sectors. Firstly, there are the barriers relating to professionals practising in different sectors. Doctors in different sectors have their own preference for clinical practices and dissimilar perspectives on outcome evaluation. Secondly, there are the information gaps. There is no effective mechanism for doctors to exchange health and patient information between the public and private sectors. Thirdly, there are the price barriers. The significant price differences between the public and the private sectors have been regarded by many practitioners as another reason for the compartmentalisation between the two sectors.

51. We fully appreciate that the private health care sector has a valuable role to play in Hong Kong. At present, about half of our registered medical practitioners practise in the private sector,

providing a wide range of primary and specialist out-patient as well as in-patient services. Unlike the public sector, the private sector offers patients the choice of doctors, and many of them are generally more flexible in responding to the patient's requests. More importantly, many private doctors have built up continuing long term relationships with their patients and the patients' families and are well respected and trusted by them. To many patients, this sense of confidence and comfort is much treasured. In short, a considerable number of patients are relying primarily on the private sector for their medical treatment, although many also seek care from the public sector at the same time. Better interface, communication and collaboration between the public and the private sectors, and among different health care providers, will be of great help to these patients by providing better continuity of care, and ensuring consistency in care practices and in assessment of health outcomes.

Proposal

52. To overcome the professional barriers, we propose that the public sector should work with the private sector in formulating common clinical protocols and mechanisms for outcome evaluation, for use, initially, in the public sector and for patients who use both the public and private sectors. The adoption of common protocols will facilitate the transfer of patients at different stages of treatment and ensure continuity of care. These efforts can be further supplemented by some shared staff training and development programmes between the two sectors. These common clinical protocols may also be used by private practitioners for their own practices.

53. With the rapid advances in information technology, it is now possible to overcome the information barriers that exist between various health care providers. In the public sector, the Hospital Authority has developed comprehensive information systems to assist in clinical management, and is planning to introduce lifelong electronic patient records for public hospital patients. We propose to develop a computer-based Health Information Infrastructure, beginning from the public health sector, extending to allow access to all health care providers, including those in the private sector, and eventually to the welfare sector. This network can provide a platform for sharing medical knowledge, information and clinical protocols, for quality assurance and patient care audit, and subject to the individual patient's wishes, for sharing of the patient records. The Health Information Infrastructure would facilitate the development of a lifelong health record for each individual.

54. The price differences between the public and the private sectors can be overcome by product differentiation. There will always be price differences between the public and the private sectors, but when patients choose a provider, they normally have regard to the entire service package. The fee level is an important factor to consider, but so are other factors, such as freedom to choose doctors, convenience and confidence. We encourage the private sector to consider further the value of product differentiation.

55. We propose that the public and private sectors should jointly explore how the two sectors can collaborate and develop

new health care products in which both sectors can participate and contribute to the benefits of the patients. Such integrated plans involving both sectors and some of their respective strengths will allow the patients another choice in seeking treatment. We encourage the medical insurance industry to develop new health care insurance policies to support such new products.

Implementation

56. The Hospital Authority will commence in 2001 promoting the development and use of common clinical protocols and sharing of staff training and development with the private sector. Each major hospital will proceed to set up a liaison network with local private practitioners, streamlining patient transfer arrangements, and reducing the need for duplication of investigations and tests upon patient transfer. The Hospital Authority will also seek the assistance of the Hong Kong Academy of Medicine and the Academy Colleges in minimising the present professional barriers.

57. The Hospital Authority will conduct a project definition study in 2001-02 on the establishment of a Health Information Infrastructure, which will support the communication and co-operation between the public and the private sectors and assist in the clinical management of individual patients. We shall pay careful and particular attention to the protection of patient records from unauthorised access.

58. We shall set up, in 2001, a task force with private sector participation to explore how public and private sectors can jointly develop some new health care products involving both sectors. For example, some better-off patients in Hospital Authority's specialist out-patient service may be attracted to return to the private sector for follow up sessions after an operation in the public sector, by the more flexible consultation hours, shorter queues and more personalised services provided in the private sector.

Facilitate Dental Care

59. On oral health and dental care, our policy has been to focus on educational and preventive efforts. Prevention assumes a special position in oral health because there is in practice no complete cure once the teeth have decayed. On the other hand, decay of teeth is preventable by good self-care efforts. Given the constraint on public revenue, public funds should be used in where the funds can help achieve the best health outcome. In the case of oral health, we consider that the public funds available should be primarily channeled to educational and preventive efforts, which will bring the best benefits to the population.

60. The Department of Health is at present offering virtually free preventive and curative care to primary students, and is providing subsidised curative service to emergency cases and persons with special needs, such as patients with haemophilia, HIV infection, severe physical or mental handicap. The role of the Department in dental care will continue in these areas but the focus in the provision of these services should be reviewed. We

recommend that curative care, in general, should be provided by private dental practitioners and non-governmental organisations.

Proposal

61. We propose that the Department of Health should review the focus of the present educational and preventive efforts and the special curative services provided. The Department should collaborate with the dental profession, the College of Dental Surgeons of Hong Kong and the Prince Philip Dental Hospital (the teaching hospital for dentists) in formulating standards, setting oral health goals, conducting surveillance programmes, promoting the importance of oral health to the community and assuring quality throughout the profession. The data obtained from the surveillance programmes will enable the Department to identify where standards and goals have not been met and to formulate strategies to deal with the problems.

62. In view of the importance of prevention in oral health, we propose that the Department of Health should explore with the dental profession how to introduce an oral health scheme for secondary students, as an extension to the school dental scheme for primary students provided by the Department. While this oral health scheme for secondary students will not be government-subsidised, the Department of Health will assist as the coordinator and facilitator and liaise with the parties concerned.

63. To assist the lower income groups to obtain quality dental care services, we propose that Government should take active

steps to encourage more non-governmental organisations to provide affordable dental care services to the public on a self-financing basis. With good preventive care starting from a young age and good oral health habits, people can generally enjoy good oral health for a long time.

Implementation

64. The Department of Health will consult all concerned parties, including the dental profession and the Prince Philip Dental Hospital, in 2001 to work out various collaboration plans, with a view to announcing the surveillance and monitoring mechanism , oral health targets and other initiatives on quality assurance and oral health promotion in 2002. Meantime, the Department of Health will intensify its educational and promotional efforts in collaboration with the dental profession.

65. The Department of Health would commence discussion with the dental profession immediately to propose the introduction of an oral health scheme for secondary students, with a view to launching the scheme in 2002.

Promote Chinese Medicine

66. Chinese medicine has been widely used in Hong Kong for many years, both as an alternative and a complement to western medicine. Its application to prevention of diseases and maintenance of health, and to treatment particularly of chronic illnesses and intractable disease is widely recognised and

acknowledged. At present, there are about 7,000 Chinese medicine practitioners practising locally, engaged in the provision of general practice, bone-setting and acupuncture services. About 22% of the medical consultations in Hong Kong are currently provided by Chinese medicine practitioners. Chinese medicine, which has benefited many millions of patients over thousands of years, has much room for growth and to contribute to Hong Kong's health care system.

67. In his 1997 as well as 1998 Policy Address, the Chief Executive affirmed his belief that Hong Kong has the potential to develop into an international centre for Chinese medicines and Chinese medicine practice. Significant developments towards achieving this goal have taken place in the past few years :-

(a) The Chinese Medicine Ordinance was enacted in July 1999, providing a statutory framework for the regulation of Chinese medicine in Hong Kong. Through a system of registration and discipline, the Ordinance recognises the professional status of Chinese medicine practitioners. The establishment of a sound regulatory system will enhance the standard of Chinese medicine and public confidence in the practice;

(b) formal education at tertiary level on Chinese medicine has been introduced in Hong Kong since 1998. Three local universities are now operating a full-time degree course on Chinese medicine; and

(c) work is in hand to set up an Institute of Chinese Medicine to carry out and co-ordinate research, help in the development of standards and assist in the improvement of the overall quality and efficacy of Chinese medicine. There has been a lot of expressed interest from the private sector in carrying out Chinese medicine research and developing the Chinese medicine industry in Hong Kong.

Proposal

68. We shall take further the above developments. Chinese medicine has been demonstrated to be very effective in the prevention of diseases and maintenance of health, and in the treatment of illnesses. The effects on the treatment of illnesses such as common cold and eczema by herbal medicine formulation and the treatment of some painful conditions and management of stroke rehabilitation by acupuncture are particularly well known. In some cases, Chinese medicine is also less costly than western medicine. The development of Chinese medicine will complement western medicine and allow patients another choice, and Chinese medicine's capability to help individual maintain health also contributes to preventive care.

69. We shall proceed expeditiously with the establishment of the regulatory system. Registration of Chinese medicine practitioners has commenced. The existing practitioners can apply to register under the transitional arrangement stipulated in the Chinese Medicine Ordinance. Under this arrangement, the more experienced practitioners may register without the need for passing an assessment or examination. The less experienced will

be given a period of time to enable them to satisfy the registration requirements. The regulation of Chinese medicines, including the registration of proprietary Chinese medicines and licensing of manufacturers and traders in Chinese medicine, will be implemented by phases, commencing in 2001. Given the large number of proprietary Chinese medicines being sold in Hong Kong, it will take several years to complete the first round of assessment of their safety, quality and efficacy.

70. We propose that the Department of Health should support the Chinese Medicine Council of Hong Kong, which was established under the Chinese Medicine Ordinance in September 1999 to regulate Chinese medicine, to liaise and co-operate with the Chinese medicine profession and trade in regard to the setting of standards, conduct of basic and clinical research, education and training of practitioners and related personnel, compilation of data and information and the promotion of safety, quality and efficacy of Chinese medicine in general. The Department should liaise with overseas regulatory authorities to keep the trade updated of the international requirements.

71. The Department of Health has set up close liaison with Chinese medicine institutions in the Mainland. The Department will not only keep up with this liaison, but will actively explore ways and means to facilitate exchange of ideas, knowledge, expertise and experience in Chinese medicine between the two places so as to support the continuous development of Chinese medicine in Hong Kong.

72. We propose to introduce the provision of Chinese medicine in the public health care system, and will, as the first step, examine how best out-patient Chinese medicine services may be provided in the public sector. Primary care is one of the strengths of Chinese medicine. This proposal will enable this strength to be maximised for the benefit of the patients.

73. We propose to pilot the practice of Chinese medicine in selected public hospitals, supporting clinical research, and facilitating the development of standards and models of interface between western and Chinese medicines. We expect that in the long term, Chinese medicine will be integrated into the public health care system, providing treatment to patients in collaboration with western medicine. Appropriate referral guidelines will be formulated based on experience to support the collaboration.

74. We encourage the Chinese Medicine Council of Hong Kong to initiate contacts with the Medical Council of Hong Kong (which regulates western medicine practitioners) and other health care profession regulatory bodies to discuss interface issues and to explore areas for collaboration for the benefit of the patients.

Implementation

75. The process to register Chinese medicine practitioners has commenced since August 2000, starting first with the registration of the existing practitioners who are exempted from the assessment and examination requirements. Following from that, the first round of assessment and examination will be held in

2001 to enable those who are not qualified for the exemption to register as soon as possible.

76. The controls over the trading and manufacture of Chinese medicines will commence by phases from 2001. The licensing and registration regulations are now being formulated by the Chinese Medicine Council of Hong Kong. The Department of Health, as the Council's executive arm, will consult the profession and trade prior to the finalisation of the regulations.

77. We shall examine options on modes of provision of out-patient Chinese medicine services in the public sector. We aim to pilot these new clinics in 2001-02.

78. We will make plans to introduce Chinese medicine practice in selected public hospitals. We expect some pilot schemes to start in 2002, which will seek to develop a framework of collaboration between Chinese and western medicines.