LCQ6: Provision of medical services for patients in remote villages

Following is a question by the Hon Kenneth Lau and a reply by the Acting Secretary for Food and Health, Dr Chui Tak-yi, in the Legislative Council today (November 4):

Question:

Some chronically ill patients living in remote villages have relayed that due to inconvenient transport and their physical weakness, they have been unable to travel a long distance to seek medical treatment on a frequent basis and, as a result, their chronic diseases have not been treated properly. On the other hand, it has been reported that as public hospitals have recently reduced non-emergency services in light of the epidemic, some community groups have introduced the Community Interim Medication Refill Scheme to provide, during the epidemic, drug refills for chronically ill patients who cannot attend follow-up consultations as scheduled. In this connection, will the Government inform this Council:

(1) of the measures in place to assist those chronically ill patients who live in remote villages and cannot attend follow-up consultations as scheduled in attending consultations expeditiously and obtaining drug refills in time;

(2) whether it will draw reference from the aforesaid medication refill scheme and expeditiously set up District Health Centres in various districts across the New Territories, so as to provide outreach medical services and drug refills for those chronically ill patients living in remote villages; and

(3) whether it will study new measures for promoting public-private partnership and medical-social collaboration, with a view to enabling those chronically ill patients living in remote villages to obtain more medical support; if so, of the details; if not, the measures in place to ensure that such chronically ill patients can obtain appropriate medical services?

Reply:

President,

In consultation with the Hospital Authority (HA), my reply to the various parts of the question raised by the Hon Kenneth Lau is as follows:

(1) Generally speaking, patients who cannot attend their follow-up appointments as scheduled can contact the relevant clinics and the clinics will make arrangements according to the actual situation, including rescheduling the appointment and providing drug refills for suitable

patients, etc. If patients cannot collect their drugs in person at the clinics, they can ask their family members or caregivers, etc. to collect the drugs on their behalf. Furthermore, the HA's "Community Geriatric Assessment Team" also regularly visits residential care homes for the elderly to provide comprehensive multi-disciplinary healthcare treatment for the residents suffering from more serious or complicated conditions who are unable to attend appointments at Specialist Out-patient Clinics due to difficulties in mobility.

In response to the COVID-19 epidemic in Hong Kong, the HA has activated the "Emergency Response Level" in public hospitals and provided assistance to patients who cannot attend their follow-up appointments at Specialist Out-patient Clinics/General Out-patient Clinics (GOPCs) due to the epidemic. Patients who cannot attend their follow-up appointments as scheduled can contact the relevant clinics and the clinics will make arrangements according to the actual situation, including providing drug refills for suitable patients. If patients cannot collect their drugs in person at the clinics, they can also ask their family members or caregivers, etc. to collect the drugs on their behalf.

Having regard to the development of local epidemic situation, the HA has progressively resumed non-emergency services since end-August to a level on a par with the same period last year. All out-patients are required to observe infection control measures, including wearing their own surgical mask, checking their temperature and making health declarations, etc. The HA will continue to closely monitor the latest development of the epidemic situation and adopt necessary and appropriate infection control measures. At the same time, it will timely adjust the service arrangements with a view to minimising the impact of the epidemic on patients.

(2) The Food and Health Bureau (FHB) is committed to enhancing district-based primary healthcare services by setting up District Health Centres (DHCs) across the territory progressively. The setting up of DHC is a key step in a bid to shift the emphasis of the present healthcare system and people's mindset from treatment-oriented to prevention-focused. Following the realisation of development plan of DHCs in three districts, namely Kwai Tsing, Sham Shui Po and Wong Tai Sin, we plan to set up DHCs in four more districts, namely Tsuen Wan, Yuen Long, Tuen Mun and Southern District, within the term of the current Government. At the same time, the FHB is inviting proposal for the operation of the smaller interim "DHC Express" in 11 districts with a target for commissioning in 2021.

At present, DHC does not provide consultation and drug refill services, but it provides services through different channels to strengthen its connection with the local community, especially with hard-to-reach community, such as outreach activities, supporting services by telephone and other communication technology, telecare platform, etc. DHC also serves the role of a hub to connect the primary healthcare services provided by the public sector, the private sector and non-governmental organisations (NGOs) in the community, with a view to providing healthcare services and information on community resources to the public, and enhancing information transparency.

DHC also strives to connect the service providers in the district in a co-ordinated manner and offer professional guidance to members of the public in need, with an aim to enhancing the overall public health standard and the public's health.

(3) The HA also collaborates with the private sector to provide more healthcare choices for patients. At present, the HA has a number of public-private partnership (PPP) initiatives, such as the GOPC PPP Programme which has been implemented in all 18 districts of Hong Kong. The Programme subsidises clinically stable patients with hypertension and/or diabetes mellitus attending the HA's GOPCs to opt for care from a private doctor of their choice to follow up on their chronic diseases, such that a long-term family doctor-patient relationship can be established for achieving the objectives of continuous and holistic primary care. The HA will carefully consider relevant factors when examining new PPP initiatives, including the potential complexity of the programmes, and the capacity and readiness of the private sector, etc. The HA will continue to communicate with the public and patient groups, and will work closely with stakeholders to explore the feasibility of introducing other PPP programmes.

On the other hand, the HA strives to strengthen collaboration with different community partners in the development of community-based services and to cater for the needs of discharged patients in various districts across the territory, including those residing in remote areas. Through medical-social collaboration, more co-ordinated medical and social care services would be provided, particularly the post-discharge support for patients in need, enabling them to stay healthy in the community and reduce unnecessary hospitalisation. On the other hand, development of medical-social collaboration would also alleviate the growing service demand and enhance the sustainability of the healthcare system.

Taking elderly service as an example, the HA has strengthened integrated transitional support services for elderly patients who are at higher risk of hospital re-admission. Healthcare professionals would assess the needs of these patients and formulate discharge plan upon patient admission, and provide post-discharge rehabilitation and nursing care support as necessary. The HA also engages NGOs to provide transitional personal care and home support services according to patients' needs after discharge. Moreover, through strengthening medical-social collaboration, the HA plans to progressively enhance the transitional post-discharge support for more elderly patients in need. The HA will continue to strengthen partnership with other organisations and provide suitable community support for patients in need through the medical-social collaboration service model.

Thank you, President.