

## **CHAPTER 2**

### **Health Bureau**

#### **District Health Centre Scheme**

**Audit Commission  
Hong Kong  
27 October 2022**

*This audit review was carried out under a set of guidelines tabled in the Provisional Legislative Council by the Chairman of the Public Accounts Committee on 11 February 1998. The guidelines were agreed between the Public Accounts Committee and the Director of Audit and accepted by the Government of the Hong Kong Special Administrative Region.*

Report No. 79 of the Director of Audit contains 8 Chapters which are available on our website at <https://www.aud.gov.hk>



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# DISTRICT HEALTH CENTRE SCHEME

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# DISTRICT HEALTH CENTRE SCHEME

## Executive Summary

1. Primary healthcare aims at improving individuals' health conditions through health promotion, disease prevention, disease management and supportive care, thereby reducing unwarranted use of hospital resources. To ensure the long-term sustainable development of the healthcare system and safeguard the health of the population, the Government is committed to actively promoting primary healthcare. In the 2017 Policy Address, the Chief Executive of the Hong Kong Special Administrative Region announced the setting up of a District Health Centre (DHC) with a brand new operation mode in the Kwai Tsing District as a pilot project within 2 years in a bid to shift the emphasis of the present healthcare system and mindset from treatment-oriented to prevention-focused. The Health Bureau (HHB) is responsible for formulating and overseeing the implementation of policies to protect and promote public health, and to provide comprehensive and lifelong holistic healthcare to each citizen. The Government set up the Steering Committee on Primary Healthcare Development (hereinafter referred to as Steering Committee) in November 2017 to draw up a development blueprint and comprehensively review the planning for primary healthcare services, and devise service models (e.g. the DHC Scheme). HHB set up the Primary Healthcare Office (PHO) in March 2019 to oversee the development and promotion strategies of primary healthcare services, including the development of the DHC Scheme.

2. Funded by the Government and operated by non-governmental organisations (NGOs) through open tenders, each DHC aims to provide primary healthcare services in a coordinated, comprehensive, continuing and person-centred manner, and also serve as a primary healthcare hub. It comprises a core centre and satellite centres, and connects a service network manned by private medical and healthcare practitioners in the district. DHCs focus on providing primary healthcare services for people of all ages on the three levels of disease prevention, namely primary prevention (i.e. health promotion and educational programmes), secondary prevention (i.e. health risk assessment and screening) and tertiary prevention (i.e. chronic disease management programmes (for diabetes mellitus (DM), hypertension (HT), low back pain and osteoarthritic knee pain) and community rehabilitation programmes (for stroke, hip fracture and post-acute myocardial infarction)). In March 2019, the operation service contract for the Kwai Tsing District

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Health Centre (K&TDHC) was awarded to an NGO (Operator A) at \$284 million for a three-year operation period. In September 2019, K&TDHC commenced operation. Subsequent to the 2017 Policy Address, the Chief Executive announced the setting up of DHCs or interim “DHC Expresses” (DHCEs) in all 18 districts within the fifth-term Government (i.e. by 30 June 2022). The Audit Commission (Audit) has recently conducted a review of the DHC Scheme and found areas for improvement.

### **Provision of services by the Kwai Tsing District Health Centre**

3. *Room for improvement in attaining service output targets.* PHO of HHB is responsible for monitoring the performance of DHC operators. Operator A is required to comply with the service contract and observe the DHC Service Manual and Guidelines (DHC Manual). Audit analysed K&TDHC’s attainment of the service output targets set out in the service contract and noted that since its commencement on 17 September 2019 and up to 31 March 2021, most of the targets were under-achieved. In 2021-22, the situation improved with 4 of the 9 targets remained under-achieved. According to HHB and K&TDHC:

- (a) in the past few years since K&TDHC commenced operation, services were disrupted due to social unrest and the coronavirus disease (COVID-19) epidemic. During the epidemic, K&TDHC was required by PHO from time to time to cease or limit face-to-face and walk-in services in order to reduce the risk of community transmission; and
- (b) K&TDHC also took up additional tasks to fight against the epidemic (e.g. operated as a vaccination centre). The anti-epidemic work had compromised K&TDHC’s capacity in the provision of the original core services.

While noting the impact brought about by the COVID-19 epidemic and the service adjustments, with the resumption of normal DHC services, HHB needs to continue to closely monitor K&TDHC’s attainment of service output targets and take further measures to enhance its performance (paras. 2.5 to 2.9).



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4. *Need to clearly and timely specify service output targets for performance monitoring.* In examining the attainment of service output targets of K&TDHC, Audit noted that there were changes in the categorisation of the services under tertiary prevention, as follows:

- (a) *Non-co-payment services under tertiary prevention.* For the chronic disease management programmes and community rehabilitation programmes, members may be eligible to attend subsidised individual healthcare services provided by network service providers (NSPs) (e.g. Chinese medicine services) or in-house healthcare professionals (e.g. dietetics sessions) under co-payment arrangements. Some other services were free of charge (i.e. non-co-payment), including group-based classes (e.g. exercise classes and health information sessions). Before April 2021, only the co-payment sessions were included for performance reporting purposes. Starting from April 2021, non-co-payment services were also counted in the achievement of targets. However, the change was included in DHC Manual only in February 2022; and
- (b) *Vaccination programmes.* While K&TDHC provided vaccination services in 2020-21 and 2021-22, it was only agreed in August 2022 to recognise the service outputs of the vaccination programmes under tertiary prevention in the reporting periods of 2020-21 and 2021-22 retrospectively (para. 2.10).

5. *Need to consider disclosing service output targets and their attainment.* From time to time, there were questions from Members of the Legislative Council and the media on the achievement of DHCs. Audit noted that HHB did not make available information on the service output targets and DHCs' attainment of the targets to the public (para. 2.13).

6. *Scope for improving attendance rates of group-based programmes.* K&TDHC organises group-based programmes under primary prevention and tertiary prevention. K&TDHC's internal guidelines state that, for most types of primary prevention programmes, the suggested minimum number of participants to conduct a class is 50% of capacity. For patient empowerment programmes under tertiary prevention, no minimum number of enrolment is set. Audit analysed the attendance records of group-based programmes conducted in September 2021 and noted that:

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- (a) for 75 (11%) of the 701 classes, only one member enrolled in each class; and
- (b) of the 362 classes with a minimum number of enrolment set in the guidelines, enrolment of 136 (38%) classes did not comply with the guidelines (paras. 2.18 and 2.19).

7. ***Need to follow up members' attendance of annual health risk assessments timely.*** Health risk assessments are conducted for early identification of chronic diseases. According to the service contract, it is expected that members attend health risk assessments annually. Audit noted that the percentage of members attending the annual health risk assessments upon membership anniversary was on the low side. For example, members registered in October 2020 were due to have annual assessments in October 2021. As of December 2021, only 9% of the members had attended the assessments (paras. 2.21 and 2.22).

8. ***Need to make further efforts in improving enrolment rates of screening programmes and tertiary prevention programmes.*** After attending the health risk assessments, members identified with high risk factors for DM/HT are referred to network medical practitioners (NMPs) for further assessment and screening. Chronic disease management programmes are provided to members who are diagnosed with DM/HT in the screening programmes, or those referred by NMPs (including those with low back pain and osteoarthritic knee pain). As for the community rehabilitation programmes, members are referred by the Hospital Authority or NMPs, so that their health conditions can be followed up. The enrolment rates measure the proportion of such members enrolling in the programmes after being referred. Audit analysed the enrolment records for the period 17 September 2019 to 31 March 2022 and noted that:

- (a) ***Screening programmes.*** The overall enrolment rates were 58% for DM and 41% for HT; and
- (b) ***Tertiary prevention programmes.*** There was room for improvement in enhancing the enrolment rates of the community rehabilitation programmes, in particular the Hip Fracture Rehabilitation Programme (31%) (paras. 2.23 and 2.25).

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9. ***Need to step up efforts in ensuring compliance with requirements relating to DHC network.*** NSPs (including NMPs) are engaged by a DHC operator to provide screening and individual healthcare services in the district concerned to form a DHC network. The operator should arrange NSPs to sign an agreement (DHC network agreement) specifying the terms and conditions of the DHC Scheme which they should accede to and comply with. The service contract and DHC Manual also stipulate the operator's roles on the management of the DHC network. There were instances of non-compliance. For example:

(a) ***Non-compliance of NSPs.*** Audit noted that:

- (i) ***NSPs not enrolled in the Electronic Health Record Sharing System (eHRSS).*** NSPs should enrol in and upload onto eHRSS all records of use of the network services by DHC members. However, 3 (2%) of the 131 NSPs were not yet ready to use eHRSS as at 31 May 2022. As a result, the 3 NSPs could not provide services to K&TDHC's members; and
- (ii) ***Withdrawals with late notifications.*** In accordance with the DHC network agreement, should NSPs wish to terminate the agreement, they should serve a notice to Operator A in writing at least 90 days in advance. Up to 31 March 2022, 18 (82%) of the 22 withdrawals had not fulfilled the notice period requirement. The delays ranged from 4 to 124 days (averaging 70 days); and

(b) ***Non-compliance of Operator A.*** Audit noted that:

- (i) ***Required number of NSPs not met in some categories.*** While the minimum number of dietitians required under the contract was 3, only 1 network dietitian was engaged as at 31 March 2022; and
- (ii) ***Inaccurate NSP information on website.*** The operator should always maintain an updated list of NSPs and make it available for members' information and choice through its website. Based on the information of NSPs on K&TDHC website as at 30 November 2021, Audit made anonymous telephone enquiries to 30 NSPs and noted that 3 NSPs (2 Chinese medicine practitioners and a speech therapist) no longer provided services in the clinics listed on the website (paras. 2.29, 2.30 and 2.32).

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10. *Need to take timely actions after inspections and expedite preparation of inspection guidelines.* PHO conducts inspection visits (service inspections and financial inspections) to DHCs. After an inspection, PHO would provide advice to the operator on irregularities identified through verbal and written communication for its immediate follow-up. A summary of the observations and recommendations for improvements on areas requiring special attention (inspection summary) would be issued to the operators. Audit found that:

- (a) for 4 financial inspections conducted up to 31 March 2022, the time taken by PHO to issue inspection summaries to K&TDHC varied significantly (ranging from 82 to 385 days, averaging 263 days);
- (b) in a financial inspection in August 2020, PHO found that Operator A had not maintained an interest-bearing account. PHO issued the inspection summary in July 2021 and Operator A took follow-up actions in September 2021; and
- (c) the inspection guidelines were under preparation (paras. 2.36 to 2.40).

11. *Need to improve timeliness of submission of reports and plans.* Operators shall submit reports and plans within specified timeframes for monitoring service performance. Since the commencement of K&TDHC and up to 31 March 2022, of the 70 reports/plans submitted, 34 (49%) were late for over 3 days, with the delays ranging from 4 to 48 days (averaging 17 days). Of the 34 delay cases, written reminders were issued on 25 (74%) occasions (para. 2.41).

### Administrative issues of the Kwai Tsing District Health Centre

12. *Need to take measures to address high staff turnover.* K&TDHC is managed by the Executive Director (overseeing the overall operation) and the Chief Care Coordinator (overseeing the clinical services). As at 31 March 2022, K&TDHC's staff establishment and strength were 81 and 67 respectively. Audit noted that:

- (a) the staff turnover rates of K&TDHC increased from 50% in 2019-20 to 101% in 2021-22; and

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- (b) there was a very high turnover of the key personnel. For example, in the period from 4 March 2019 to 31 March 2022, 3 Executive Directors had resigned and each of them had served K&TDHC for a short period of time (ranging from 5 to about 7 months) (paras. 3.2 to 3.4).
13. ***Need to fulfill manpower requirement and address shortage of core staff.*** The service contract has stipulated the minimum number of healthcare professionals and the essential services required. Also, the operator should deploy a team of core staff for the provision of services throughout the 3-year operation period. Audit found that the required numbers of staff were not met for some positions. For example, K&TDHC should have 5 social workers in the core team. However, only 2 social workers were employed as at 31 March 2022 (para. 3.6).
14. ***Need to ensure compliance with procurement guidelines.*** In making procurement with DHC funding, the operator should strictly observe the government quotation requirements. Audit noted that there were three different sets of guidelines governing procurement matters of K&TDHC, namely Operator A's Guidelines, DHC Manual and K&TDHC Operations Manual, and found instances of non-compliance with the guidelines. For example, for purchases made in the period from March 2019 to December 2021:
- (a) ***Quotation requirement not met.*** For 30 purchases with an amount not exceeding \$5,000 selected for audit examination, 13 (43%) were with one quotation only, contrary to the requirement of obtaining two written quotations as far as practicable stated in DHC Manual and K&TDHC Operations Manual; and
- (b) ***Tenders not conducted.*** According to Operator A's Guidelines and K&TDHC Operations Manual, open tenders should be conducted for purchases over \$200,000. Audit found that for 4 such purchases, no tender had been conducted. Instead, quotations were obtained (paras. 3.10, 3.11 and 3.14).
15. ***Need to step up efforts in promoting K&TDHC.*** The DHC Scheme aims at serving members at all ages. Audit analysed K&TDHC members' age profile and compared it with the age profile of residents in the Kwai Tsing District and noted that as at 31 March 2022, the percentage of residents in the Kwai Tsing District who

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joined as K&TDHC members, in particular for the younger age group (i.e. aged 44 or below), was on the low side. There is room for recruiting more members especially among the younger population (paras. 3.21 and 3.22).

### Provision of District Health Centres and District Health Centre Expresses

16. *Need to ensure that DHCs commence operation as scheduled.* As announced in the 2019 Policy Address, the Government would set up DHCs in 7 districts and DHCEs in the remaining 11 districts within the fifth-term Government (i.e. by 30 June 2022). As at 30 June 2022, 4 DHCs and 11 DHCEs were in operation. For the remaining 3 DHCs, upon agreement with the operators, the commencement dates had been revised from July 2022 to October 2022 for Southern and Yuen Long DHCs, and from November 2022 to December 2022 for Tsuen Wan DHC (paras. 4.2 and 4.3).

17. *Need to continue efforts in setting up DHCs at permanent sites.* The Government indicated in the 2018 Policy Address that to ensure service stability, it would reserve premises for DHCs within Government properties, but would first rent suitable premises to enable early service delivery. As of June 2022, while suitable sites had been earmarked for the long-term development of DHCs in all 18 districts, the availability dates had not yet been confirmed for 7 districts (i.e. 4 districts with full-fledged DHCs and 3 districts with DHCEs) (para. 4.4).

18. *Need to monitor performance of DHCEs.* The Government pledged in the 2019 Policy Address that for the remaining 11 districts with full-fledged DHCs yet to be set up within the fifth-term Government, smaller-scale DHCEs would be established in the interim. In April 2021, by an invitation for proposals, HHB awarded contracts to NGOs for the operation of the 11 DHCEs at \$596 million for a three-year operation period (i.e. an average of about \$18 million per annum for each district). The 11 DHCEs commenced operation in September and October 2021. The Government set out 4 service output targets. Audit noted that:

- (a) as of August 2022, the statistics on DHCEs' attainment of the 2 service output targets under tertiary prevention was not yet available due to system limitations; and

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- (b) for one service output target each under primary and secondary prevention, as DHCE staff had been deployed to support the Hospital Authority's COVID-19 hotlines and designated clinic appointment hotline since February and March 2022 respectively, it was agreed between PHO and DHCE operators to deduct the annual service output targets by one-sixth. Taking into account the adjustments, for the first two quarters ended 31 March 2022, of the 11 DHCEs, 7 (64%) DHCEs attained over 100% of the primary prevention service output target and 6 (55%) DHCEs attained above 60% of the secondary prevention service output target (paras. 4.9 to 4.12).

19. ***Need to fulfill required number of DHCEs' healthcare service providers.***

According to the service contracts of DHCEs, operators should engage and maintain a certain number of healthcare service providers (e.g. medical practitioners and allied health professionals) to provide services (e.g. laboratory investigations and optometry assessments). Audit noted that, as at 31 March 2022, a significant number of DHCEs failed to engage and maintain the committed number for the mandatory categories of healthcare service providers. For example, 8 (73%) of the 11 DHCEs failed to engage and maintain the committed number of accredited laboratories (paras. 4.14 and 4.15).

20. ***Need to keep under review the accessibility of DHCE services.***

According to the terms of the invitation for proposals, operators of DHCEs should set up in each district a core centre to serve as its primary service site. They are also encouraged to set up additional service points to improve accessibility. Audit noted that the number of service points of the 11 DHCEs ranged from 1 (for 3 DHCEs) to 9 (for 2 DHCEs), and that the number of service locations was not directly proportional to the population in the district nor the land area served (paras. 4.16 and 4.17).

21. ***Need to keep under review the governance structure of DHCEs.***

Under the current governance structure of the DHC Scheme, the Steering Committee oversees high level issues concerning DHCs and DHCEs. For DHCs, the cluster-level Governing Committees and DHC-specific Executive Committees have also been established to provide guidance and oversight to DHC operators. While DHCEs are one of the key service providers of district-based primary healthcare until the bulk of full-fledged DHCs are set up (i.e. in 2024 to 2030), the structure with multiple levels of oversight and the reporting requirements adopted by DHCs are not in place for DHCEs (paras. 4.19 and 4.20).

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22. *Need to improve dissemination of service information on websites.* Audit noted the following issues:

- (a) *PHO one-stop website.* PHO has set up a one-stop website to provide information of the DHC Scheme, which also contains information on each of the DHCs and DHCEs. Audit found that, as at 31 May 2022, information about DHCs' satellite centres and DHCEs' service points was not provided; and
- (b) *DHCEs' dedicated websites.* As at 31 May 2022, all 11 DHCEs had set up dedicated websites. Audit noted that the amount of information available varied and some of the information provided was inaccurate. For example, information on addresses and opening hours of service points was available on 8 (73%) and 7 (64%) of the 11 DHCEs' websites respectively (paras. 4.25 and 4.27).

23. *Need to enhance collaboration with other primary healthcare service providers.* As announced in the 2021 Policy Address, HHB, with the advice from the Steering Committee, has proceeded with a comprehensive review on the planning of primary healthcare services and governance framework to formulate a blueprint for the sustainable development of primary healthcare services in Hong Kong with a view to creating a sustainable healthcare system, improving the overall health status of the population and reduce avoidable demand for secondary and tertiary healthcare. According to a paper on the blueprint submitted to the Steering Committee, the Government recognises that the current primary healthcare system is fragmented with a lack of overall strategic planning and coordination on service development and integration, which has resulted in inefficiencies in resource use and misalignment of incentives. Besides, while a service interface mechanism has been set up between the Elderly Health Centres of the Department of Health and DHCs (elders who are on the waiting list and wish to enrol as new members of the Elderly Health Centres are offered an alternative option of DHCs), Audit noted that the arrangement was only applicable to DHCs but not for DHCEs (paras. 4.35 to 4.38).

24. *Need to take into account audit findings in launching full-fledged DHCs.* Audit noted that the targets set for the DHC/DHCE operators were mainly on service output. As DHCs will become a key component of the primary healthcare system, HHB needs to consider setting outcome targets and/or indicators for measuring the effectiveness of the DHC Scheme in the longer term. As the service model and scale



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of DHCs continue to grow and evolve, HHB also needs to take into account the audit observations and recommendations in this Audit Report in launching full-fledged DHCs and refining the DHC Scheme (para. 4.39).

### Audit recommendations

25. Audit recommendations are made in the respective sections of this Audit Report. Only the key ones are highlighted in this Executive Summary. Audit has *recommended* that the Secretary for Health should:

#### *Provision of services by the Kwai Tsing District Health Centre*

- (a) continue to closely monitor K&TDHC's attainment of service output targets and take further measures to enhance its performance (para. 2.14(a));
- (b) clearly and timely specify the service output targets in DHC Manual in case there are further changes to DHC services or the definition of the targets upon review (para. 2.14(b));
- (c) consider disclosing the service output targets and the attainment of DHCs to the public (para. 2.14(c));
- (d) closely monitor K&TDHC's actions to improve service delivery, including:
  - (i) improving the attendance rates of the group-based programmes (para. 2.27(b)(i));
  - (ii) ensuring that members attend annual health risk assessments timely (para. 2.27(b)(ii)); and
  - (iii) enhancing the enrolment rates of the screening programmes and tertiary prevention programmes (para. 2.27(b)(iii));

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- (e) **step up monitoring of K&TDHC's compliance with the requirements in relation to the management of network services and provide assistance to address related issues as appropriate (para. 2.34);**
- (f) **remind DHC operators to take timely actions to rectify deficiencies identified in PHO's inspections and expedite the preparation of the inspection guidelines, which should cover timeframes for issuing inspection summaries to operators (para. 2.45(a) and (b));**
- (g) **continue to monitor K&TDHC's compliance with the submission deadlines of reports and plans stipulated in the service contract (para. 2.45(d));**

### ***Administrative issues of the Kwai Tsing District Health Centre***

- (h) **closely monitor K&TDHC's actions to address the high staff turnover and its compliance with the manpower requirements in the service contract (para. 3.8(a) and (b));**
- (i) **continue to closely monitor the measures taken by K&TDHC to ensure compliance with the procurement guidelines (para. 3.18(b));**
- (j) **remind K&TDHC to strengthen its promotion efforts, including stepping up efforts to raise the public awareness of its function and to attract new members, in particular from the younger population (para. 3.25(a));**

### ***Provision of District Health Centres and District Health Centre Expresses***

- (k) **closely monitor the progress of the preparation work to ensure that Southern, Yuen Long and Tsuen Wan DHCs commence operation according to the schedule (para. 4.7(a));**
- (l) **continue efforts in setting up DHCs at the permanent sites (para. 4.7(b));**

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- (m) **closely monitor the performance of DHCEs and their compliance with the contract requirement on engaging healthcare service providers (para. 4.22(a) and (b));**
- (n) **keep under review the accessibility of DHCE services, taking into account the service demand, user feedback and the number of service locations of DHCEs, and take follow-up actions as appropriate (para. 4.22(c));**
- (o) **keep under review the governance structure for overseeing DHCEs and take follow-up actions as appropriate (para. 4.22(d));**
- (p) **enhance the dissemination of information about the DHC Scheme on websites, including providing information about DHCs' satellite centres and DHCEs' service points on PHO's one-stop website, and encouraging operators of DHCs/DHCEs to provide more information on the dedicated websites (para. 4.33(a));**
- (q) **continue to explore ways to enhance the collaboration among DHCs and other primary healthcare service providers in the delivery of primary healthcare services (para. 4.40(a));**
- (r) **consider setting outcome targets and/or indicators for measuring the effectiveness of the DHC Scheme in the longer term (para. 4.40(b)); and**
- (s) **take into account the audit observations and recommendations in this Audit Report in launching full-fledged DHCs and refining the DHC Scheme (para. 4.40(c)).**

## **Response from the Government**

26. The Secretary for Health agrees with the audit recommendations.



## PART 1: INTRODUCTION

1.1 This PART describes the background to the audit and outlines the audit objectives and scope.

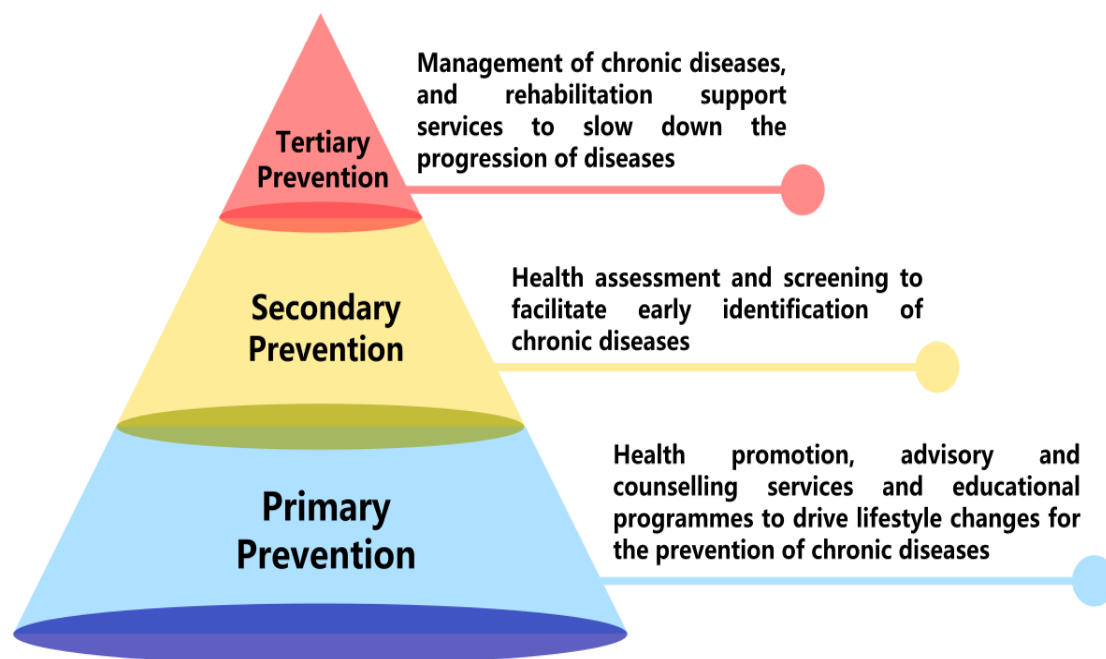
### *Background*

1.2 According to the Government, life expectancy of the population of Hong Kong ranks first globally. Due to an ageing population and increasing prevalence of chronic and complex diseases, the healthcare system is under mounting pressures and challenges. To ensure the long-term sustainable development of the healthcare system and safeguard the health of the population, the Government is committed to actively promoting primary healthcare.

1.3 ***Primary healthcare.*** Primary healthcare is an essential part of a healthcare system, which should be the first point of contact for individuals in a continuing healthcare process which entails the provision of accessible, comprehensive, continuing, coordinated and person-centred care in the community. As opposed to secondary healthcare which is curative in nature, primary healthcare aims at improving individuals' health conditions through health promotion, disease prevention, disease management and supportive care, thereby reducing or delaying the need for more intensive medical care. An individual can enjoy continuous, lifelong, comprehensive and holistic healthcare with emphasis on preventive care and promotion of well-being. A comprehensive and coordinated primary healthcare system would enhance overall public health and reduce unwarranted use of hospital resources. Primary healthcare can be further categorised into primary prevention, secondary prevention and tertiary prevention (see Figure 1).

Figure 1

### Three levels of primary healthcare



Source: Health Bureau records

### ***Government efforts in strengthening district-level primary healthcare services***

1.4 According to the Government, it has been delivering the public primary healthcare (Note 1) through services of the Department of Health (DH — Note 2) and

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**Note 1:** According to the Government, about 70% of the total expenditure on primary healthcare services in Hong Kong belongs to the private sector.

**Note 2:** DH is the Government's health adviser and agency to execute healthcare policies and statutory functions. It safeguards the community's health through a range of promotional, preventive, curative and rehabilitative services. Healthcare services are being delivered using a life-course approach through DH's various areas of work with an emphasis on preventive care. For instance, it provides programme-based primary healthcare services such as cervical/breast cancer screening for prevention and early diagnosis of cancers. 18 Elderly Health Centres have also been set up to provide health assessment, physical check-up, counselling, curative treatment and health education services to the elderly by a multidisciplinary team including doctors, nurses and allied health professionals.

the Hospital Authority (HA — Note 3). The major primary healthcare development milestones are shown at Appendix A.

**1.5 District Health Centre (DHC) Scheme.** The Government is determined to step up efforts to promote individual and community involvement, enhance coordination among various medical and social (in both the public and private) sectors, and strengthen district-level primary healthcare services. In the 2017 Policy Address, the Chief Executive of the Hong Kong Special Administrative Region announced the setting up of a DHC with a brand new operation mode in the Kwai Tsing District as a pilot project within 2 years (i.e. by 2019) in a bid to shift the emphasis of the present healthcare system and mindset from treatment-oriented to prevention-focused.

**1.6 Steering Committee on Primary Healthcare Development (hereinafter referred to as Steering Committee).** The Steering Committee was established in November 2017 (Note 4). It is tasked to draw up a development blueprint and comprehensively review the planning for primary healthcare services, and devise service models via district-based medical-social collaboration in the community (e.g. the DHC Scheme).

**1.7 Health Bureau (HHB) and Primary Healthcare Office (PHO).** The then Food and Health Bureau (FHB) was responsible for formulating and overseeing the implementation of policies to protect and promote public health, and to provide comprehensive and lifelong holistic healthcare to each citizen. Pursuant to the reorganisation of government structure which took effect from 1 July 2022, HHB was

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**Note 3:** *HA was established under the Hospital Authority Ordinance (Cap. 113). Apart from offering curative healthcare services (e.g. hospital services), it also provides a range of primary healthcare services in the community, including general out-patient services, multi-disciplinary services, chronic disease management programmes including risk assessment and management programme and nurse and allied health clinics, and community nursing services.*

**Note 4:** *The Steering Committee is chaired by the Secretary for Health, and comprises key representatives from the medical and healthcare professions (e.g. family medicine, nursing, physiotherapy and occupational therapy), academia, non-governmental organisations and district groups. Ex-officio members include directorate officers of the Health Bureau, the Labour and Welfare Bureau, DH, the Home Affairs Department and HA. Members of the Committee are appointed by the Secretary for Health for a term of three years.*

## Introduction

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formed to take up these responsibilities (Note 5). Team 5 of HHB is responsible for policy issues on primary healthcare including those relating to the DHC Scheme, formulation of a blueprint for the sustainable development of primary healthcare services and provision of secretarial support to the Steering Committee. HHB set up PHO in March 2019 to oversee the development and promotion strategies of primary healthcare services, including the development of the DHC Scheme and monitoring the performance of DHC operators (Note 6). An extract of the organisation chart of HHB as at 1 July 2022 is shown at Appendix B.

1.8 **Governance structure.** Apart from the Steering Committee which devises the service model of the DHC Scheme, the Government has established various committees at different levels to steer and oversee the planning and implementation of the DHC Scheme and also to monitor the operation of DHCs, including:

- (a) **Cluster-level Governing Committees.** A Governing Committee (Note 7) oversees a cluster of DHCs and provides guidance and oversight to DHC operators (e.g. monitor the progress of service implementation and ensure that objectives/service requirements are met), and also to facilitate experience sharing, growth and development of DHC services. For example, the Kowloon and New Territories South District Health Centre Governing Committee (hereinafter referred to as the Governing Committee)

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**Note 5:** *With effect from 1 July 2022, the Food Branch of the then FHB (responsible for policies on environmental hygiene, food safety, agriculture and fisheries, veterinary public health etc.) has been transferred to the Environment and Ecology Bureau. The Health Branch of the then FHB has been revamped as HHB. For simplicity, in this Audit Report, the then FHB and the then Secretary for Food and Health are also referred to as HHB and the Secretary for Health.*

**Note 6:** *The revised estimated expenditure for 2021-22 on “Other charges — primary healthcare development expenses of HHB was \$200.3 million, which included the expenses for the set-up and operation of DHCs, and other primary healthcare development expenses. HHB also has an approved non-recurrent commitment for the “DHC Express” Scheme (see para. 1.15) for a three-year operation period of \$596.2 million.*

**Note 7:** *With the Under Secretary for Health serving as the Advisor, a Governing Committee is chaired by the Assistant Commissioner of Primary Healthcare and comprises representatives from relevant professions, ex-officio members of various government bureaux/departments, District Councillors, and key personnel (i.e. Executive Director and Chief Care Coordinator) of the respective DHCs. Members of the Committees are appointed for a term of three years.*



oversees the cluster of DHCs in the Kwai Tsing, Sham Shui Po, Wong Tai Sin and Tsuen Wan Districts; and

- (b) ***DHC-specific Executive Committees.*** An Executive Committee (Note 8) is formed for each DHC. PHO provides policy guidance and strategies on the management and operation, and work with the DHC operator on the detailed service operation of the respective DHC in the Executive Committee. For example, the Kwai Tsing District Health Centre Executive Committee (hereinafter referred to as the Executive Committee) provides advice and monitors the implementation of the services of the Kwai Tsing District Health Centre (K&TDHC) in accordance with the terms and conditions set out in the service contract.

Appendix C shows the governance structure overseeing the DHC Scheme as at 30 June 2022.

### ***Features of DHCs***

1.9 With the advice of the Steering Committee (see para. 1.6), HHB conducted various stakeholders engagement exercises to formulate details on the operation of the pilot DHC in the Kwai Tsing District. The salient features of DHCs include the following:

- (a) ***Objectives.*** Each DHC aims to provide primary healthcare services in a coordinated, comprehensive, continuing and person-centred manner, and also serve as a primary healthcare hub in the district. Through stepping up efforts in promoting individual and community involvement, enhancing coordination among various medical and social (in both the public and private) sectors, and strengthening district-level primary healthcare services, the Government aims to encourage the public to maintain a healthy lifestyle and enhance their capability in self-care and home care, thereby reducing the demand for specialist services and hospitalisation that would be largely avoidable;

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**Note 8:** *An Executive Committee is co-chaired by the Director (DHC) of PHO and a delegate of the DHC operator, and comprises representatives of PHO, and the operator and the key personnel of the DHC.*

## Introduction

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- (b) ***Service model.*** Funded by the Government and operated by non-governmental organisations (NGOs) through open tenders, each DHC connects a service network manned by private medical and healthcare practitioners in the district. DHCs engage primary healthcare service providers, including medical practitioners and allied health professionals (e.g. physiotherapists, occupational therapists, optometrists and dietitians) in the private sector practising either in the district or the adjoining districts (hereinafter referred to as network service providers (NSPs)) to build a DHC network in the district. DHC operators also reach cooperation agreements with other NGOs in the district on, among other things, membership referrals and organisational activity support to leverage the benefits of service networking in the corresponding district;
  - (c) ***Core DHC and satellite centres.*** Each district is served by a core DHC as a service hub and complemented by satellite centres (and service points if applicable — Note 9) in each of the sub-districts within the district. The DHC strives to better coordinate with other district-based primary healthcare services and facilities, making it more convenient to meet individual healthcare needs of the community; and
  - (d) ***DHC members.*** DHCs provide primary healthcare services which cater for people of all ages. An individual who is a Hong Kong resident, is living or working in the district of the corresponding DHC, and agrees to enrol to the Electronic Health Record Sharing System (eHRSS — Note 10) can register as a DHC member. An individual can only register with one DHC.
- 1.10 ***DHC services.*** DHCs focus on providing primary healthcare services on the three levels of disease prevention (see Figure 1 in para. 1.3), namely:
- (a) ***Primary prevention.*** With a view to enhancing public awareness of disease prevention and their capability in self-management of health, the services

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**Note 9:** *In a tender exercise of a DHC service contract, potential operators may propose to set up additional service point(s), i.e. service outlet(s) in addition to the core centre and satellite centres in relation to the provision of services.*

**Note 10:** *Developed by HHB, eHRSS provides an electronic platform that aims to build up free and lifelong electronic health records for all members of the public.*

cover education on healthy lifestyle such as healthy diet, weight management and stress management;

- (b) ***Secondary prevention.*** It includes health risk assessment for members and screening for targeted groups (e.g. members with high risk factors) to facilitate early identification of chronic diseases; and
- (c) ***Tertiary prevention.*** It includes chronic disease management and community rehabilitation. DHC members diagnosed with chronic diseases (e.g. diabetes mellitus (DM) and hypertension (HT)) would be arranged to join DHC chronic disease management programmes. Besides, community rehabilitation programmes are offered to support patients with stroke, hip fracture and post-acute myocardial infarction who have already completed the rehabilitation programmes at hospitals but require extended care and rehabilitation in the community.

### ***K&TDHC***

1.11 With the features of DHCs formulated, HHB conducted an open tender for the operation of K&TDHC in September 2018. In March 2019, the operation service contract for K&TDHC was awarded to an NGO (hereinafter referred to as Operator A) at a contract amount of \$284 million for a three-year operation period. In September 2019, K&TDHC commenced operation. The core centre of K&TDHC (see Photograph 1) is located in Kwai Chung with a net operating floor area of about 1,500 square metres, and houses a team covering nurses, allied health professionals, pharmacists, social workers and supporting staff to provide government subsidised primary healthcare services.

1.12 In determining the scope of services to be provided by K&TDHC, the Steering Committee (see para. 1.6) had examined findings of large scale surveys and data sources to better understand the health profile of the population of the Kwai Tsing District. According to the Steering Committee, resources should be directed to tackle the most prevalent chronic diseases that consume substantial medical resources, and explore how to manage their conditions through risk management and early intervention, thereby reducing the unwarranted use of hospital resources. As such, K&TDHC accorded priority in handling the most prevalent chronic diseases (i.e. DM, HT and musculoskeletal disorders) and health risk factors (e.g. fall risk and unhealthy diet) identified in the district.

**Photograph 1**

**Core centre of K&TDHC**



*Source: K&TDHC records*

1.13 ***Monitoring and evaluation study.*** To assess the overall performance of services provided by K&TDHC, HHB commissioned a tertiary institution in August 2019 to conduct a monitoring and evaluation study, covering aspects including the quality and effectiveness of the DHC services. As of June 2022, two interim reports had been submitted to HHB. The final report will be submitted by end-2023. According to the Government, it will take into account the result of the study and the operation experience of K&TDHC to enhance the operation model of the DHC Scheme and to formulate the development direction of primary healthcare.

### ***DHCs in other districts***

1.14 Subsequent to the 2017 Policy Address, the Chief Executive announced proposals and updates about the development of DHCs in subsequent Policy Addresses, as follows:

- (a) ***2018 Policy Address.*** The Government would proactively take forward the setting up of DHCs in other districts, with K&TDHC as the blueprint. To ensure service stability, the Government would reserve premises for DHCs

within Government properties in various districts, but would first rent suitable premises to enable early service delivery;

- (b) **2019 Policy Address.** The Government would expedite the setting up of DHCs in all 18 districts. It was expected that within the fifth-term Government (i.e. by 30 June 2022), DHCs in 6 more districts (i.e. a total of 7 DHCs) and interim “DHC Expresses” (DHCEs) (see para. 1.15) in the remaining 11 districts would be established to provide health promotion, consultation and chronic disease management;
- (c) **2020 Policy Address.** Apart from K&TDHC which had commenced operation in September 2019, operation service contracts for DHCs of another 2 districts were awarded, and the sites of 9 other DHCs had been confirmed; and
- (d) **2021 Policy Address.** After years of hard work, the Government had and was going to set up DHCs in Kwai Tsing, Sham Shui Po, Wong Tai Sin, Tuen Mun, Southern, Yuen Long and Tsuen Wan, and DHCEs had also been set up in another 11 districts.

1.15 **DHCEs.** The Government saw the need to build up a critical mass of district-based primary healthcare services throughout the territory as early as practicable to maintain the momentum for promoting primary healthcare. Since the hardware development (whether within Government or Hong Kong Housing Authority-owned or leased premises) is heavily constrained, HHB has allocated around \$600 million over a three-year period to fund NGOs (by invitation for proposals) to set up smaller interim DHCEs in the remaining 11 districts where full-fledged DHCs are yet to be set up within the fifth-term Government. The objectives of the DHCEs are:

- (a) to deliver district-based primary healthcare services pending the set-up of full-fledged DHCs; and
- (b) to facilitate the provision of comprehensive community medical-social support to the public through identification of healthcare and social resources and early engagement of the community service partners in the districts.

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1.16 The DHCE operator in each district is required to identify a core site for its services, and is encouraged to set up service points to enhance the accessibility of services. While the scope of services is modelled on full-fledged DHCs (see para. 1.10), appropriate modifications are made to keep the DHCE operation on a manageable scale (e.g. DHCEs are not required to provide community rehabilitation services). According to the Government, it will take forward the works projects required for DHC premises in all districts. The operators of DHCs will continue to be awarded through open tenders as and when the premises are ready. The DHCE services will migrate as appropriate to the local DHCs. As at 30 June 2022, apart from K&TDHC, 3 full-fledged DHCs and 11 DHCEs were in operation, while the remaining 3 full-fledged DHCs were expected to commence operation within 2022 (see Table 1):

**Table 1**  
**Status of provision of DHCs and DHCEs**  
**(30 June 2022)**

Status	No. of districts	District	Actual/expected commencement date
<i>DHC</i>			
Operation commenced	4	Kwai Tsing	September 2019
		Sham Shui Po	June 2021
		Tuen Mun	May 2022
		Wong Tai Sin	June 2022
Contract awarded	3	Southern, Yuen Long	October 2022
		Tsuen Wan	December 2022
<i>DHCE</i>			
Operation commenced	11	Sai Kung	September 2021
		Central and Western, Eastern, Islands, Kowloon City, Kwun Tong, North, Sha Tin, Tai Po, Wan Chai and Yau Tsim Mong	October 2021

Source: Audit analysis of HHB records

***Service disruptions and alternative functions of DHCs/DHCEs in light of coronavirus disease (COVID-19) epidemic***

1.17 According to HHB, each DHC/DHCE plays a vital role in delivering public health functions at the community level especially during an epidemic that members of the public depend on the resources available in their vicinity. During the COVID-19 epidemic, DHCs/DHCEs were required by PHO from time to time to cease/limit face-to-face and walk-in services in order to reduce the risk of community transmission from January 2020 to May 2022 (Note 11). To strengthen community support to fight against the epidemic, DHCs and DHCEs have shifted their focus and participated in anti-epidemic work at the district level including the following:

- (a) ***Disease-related public education.*** For example, K&TDHC has set up a community anti-epidemic information centre for distributing support information and resources;
- (b) ***COVID-19 vaccination programme.*** Since January 2022, DHCs/DHCEs have assisted members of the public to make appointments for vaccination at community vaccination centres, mobile vaccination stations and private service providers. Furthermore, to enable the public to get vaccinated as soon as possible and boosting the vaccination rate further, K&TDHC and Sham Shui Po DHC operated as COVID-19 vaccination centres from February/March to May 2022. Both DHCs have also been providing home vaccination services since April 2022 for unvaccinated elderly aged 70 or above and persons with impaired mobility;
- (c) ***Distribution of rapid antigen test kits.*** DHCs/DHCEs have been distributing rapid antigen test kits to elderly aged 60 or above since April 2022, and supporting them in getting used to self-administering the tests for early identification of the infected and cutting the virus transmission chains in the community;
- (d) ***Hotline services.*** During the fifth-wave of the outbreak, DHCEs deployed staff to HA to support the COVID-19 hotlines and designated clinic appointment hotlines from 15 February to 30 April 2022; and

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**Note 11:** *According to PHO, K&TDHC was closed from 7 February to 15 March 2020. In some intermitting periods from January 2020 to February 2021, it provided limited services by appointment only. From 10 January to 22 May 2022, it provided vaccination support services and provided limited services by online media only.*

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- (e) ***Post-discharge support.*** DHCs/DHCEs provide multi-disciplinary post-discharge support to suitable patients who have recovered from COVID-19, including but not limited to pathology explanation, infection control, emotional support and restructuring of lifestyle, upon referral by public hospitals in the districts.

## Audit review

1.18 In November 2021, the Audit Commission (Audit) commenced a review of the DHC Scheme. In conducting this review, Audit selected K&TDHC for detailed examination as the centre had been in operation for over two years since its opening in September 2019, and that the Government uses K&TDHC as the blueprint for progressively implementing full-fledged DHCs in other districts (see paras. 1.5 and 1.14). The audit review has focused on the following areas:

- (a) provision of services by K&TDHC (PART 2);
- (b) administrative issues of K&TDHC (PART 3); and
- (c) provision of DHCs and DHCEs (PART 4).

Audit has found room for improvement in the above areas and has made a number of recommendations to address the issues.

## General response from the Government

1.19 The Secretary for Health appreciates Audit's efforts in conducting the review and putting forward recommendations to help improve the DHC Scheme, and agrees with the audit recommendations. He has said that:

- (a) the COVID-19 epidemic over the past almost three years on the one hand had called upon DHCs and DHCEs to shift their capacity towards participating actively in anti-epidemic work at the district level, and on the other hand constrained the promotion and delivery of their original planned services as well as the willingness of the target groups to attend such services;



- (b) in addition, since the DHC Scheme is a brand new mode of operation in Hong Kong, HHB has been conducting on-going reviews and adjustments in the process to improve the DHC services in the context of its reform to the primary healthcare system; and
- (c) HHB will take into account the audit observations and recommendations in this Audit Report together with the Primary Healthcare Blueprint which will be published within 2022 for refining the DHC Scheme to provide quality primary healthcare services to the public.

## Acknowledgement

1.20 Audit would like to acknowledge with gratitude the full cooperation of the staff of HHB and K&TDHC during the course of the audit review.

## **PART 2: PROVISION OF SERVICES BY THE KWAI TSING DISTRICT HEALTH CENTRE**

2.1 This PART examines issues relating to the provision of services by K&TDHC, focusing on:

- (a) performance management (paras. 2.5 to 2.15);
- (b) service delivery (paras. 2.16 to 2.28);
- (c) management of network services (paras. 2.29 to 2.35); and
- (d) service and financial monitoring (paras. 2.36 to 2.46).

### ***Background***

2.2 The service contract for the operation of K&TDHC was awarded to Operator A in March 2019 for a three-year operation period (Note 12). K&TDHC commenced operation on 17 September 2019 (Note 13) to provide primary healthcare services in the Kwai Tsing District, with a core centre serving as its headquarters and complemented by 5 satellite centres and a service point (Note 14).

2.3 ***Organisation and expenditure of K&TDHC.*** K&TDHC is managed by an Executive Director who oversees the operation and strategic development of K&TDHC. The Executive Director is supported by a Chief Care Coordinator who oversees the

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**Note 12:** *The original contract sum was \$284 million. In April 2020, the Government issued an updated instruction to Operator A with additional operational requirements (e.g. assisting on all administrative matters in respect of using Elderly Health Care Voucher (see Note 1 to Appendix A) to settle co-payment in DHC and the DHC network, and provision of subsidised podiatric services under the HT Management Programme). In view of the additional requirements, the total contract sum was revised to \$304 million.*

**Note 13:** *According to HHB, while the official opening ceremony was held on 24 September 2019, K&TDHC started providing services on 17 September 2019.*

**Note 14:** *In the tender exercise of K&TDHC service contract, Operator A proposed and the Government accepted to set up a service point to support the service of one of the 5 satellite centres (see para. 1.9(c)).*

provision and development of clinical services. Other staff include care coordinators, allied health professionals (e.g. physiotherapists), social workers and administrative staff. As at 31 March 2022, the staff establishment and strength of K&TDHC were 81 and 67 respectively. K&TDHC's expenditures for 2019-20, 2020-21 and 2021-22 were \$17.7 million, \$37.1 million and \$42.8 million respectively.

2.4 ***Services provided by K&TDHC.*** A DHC aims to provide primary healthcare services in a coordinated, comprehensive, continuing and person-centred manner, and also serve as a primary healthcare hub in the district. Upon the advice of the Steering Committee (see para. 1.6), K&TDHC accords priority in handling the most prevalent chronic diseases (i.e. DM, HT and musculoskeletal disorders) and health risk factors (e.g. fall risk and unhealthy diet) identified in the district (see para. 1.12) covering all the three levels of prevention of primary healthcare. Figure 2 shows the “client journey” of a K&TDHC member (see para. 1.9(d)). The details of the services are summarised as follows:

- (a) ***Primary prevention.*** K&TDHC offers a wide range of free health-related programmes which aim at enhancing public awareness of disease prevention and their capability in self-management of health by facilitating lifestyle changes for prevention of chronic diseases. These include group activities (e.g. exercise classes) and health seminars (e.g. healthy diet) covering a wide range of health-related topics. It also provides psychological and social support services (e.g. classes on methods of stress reduction) to promote physical and mental health. In addition, volunteer training workshops are provided to share basic health management knowledge and skills to the community, and to build neighbourhood support networks to promote mutual care;
- (b) ***Secondary prevention.*** It includes:
  - (i) ***Health risk assessment.*** K&TDHC offers annual health risk assessments to members conducted by the centre's healthcare staff free of charge to facilitate early identification of the target chronic diseases and health risk factors. Based on the assessment results, the staff will work with the member to identify health concerns for the development of a personalised self-health management plan, and recommend appropriate group activities (see (a)). If necessary, the member will be advised to receive chronic disease screening, i.e. referred to network medical practitioners (NMPs) for further examination and diagnosis at a subsidised rate; and

- (ii) ***Chronic disease screening.*** If the member is found to be at risk of developing DM or HT after the health risk assessment, he/she will be referred to enrol in a screening programme for further examination and diagnosis by K&TDHC's NMPs. The screening programme includes two medical consultations at a subsidised rate (consultation fee of up to \$250 per consultation subsidised by the Government and any extra amount (if any) paid by the member as co-payment), and one medical laboratory test at a subsidised rate (co-payment by the member capped at \$150 and the extra amount subsidised by the Government); and
- (c) ***Tertiary prevention.*** It includes:
  - (i) ***Chronic disease management programmes.*** Currently, there are four chronic disease management programmes, covering DM, HT, low back pain and osteoarthritic knee pain. Members diagnosed with DM/HT by NMPs in the chronic disease screening (see (b)(ii)) are eligible to join the management programmes. Referrals are also made by NMPs on individuals diagnosed with the abovementioned four chronic diseases to join as members of K&TDHC and to enrol in the relevant programmes; and
  - (ii) ***Community rehabilitation programmes.*** There are three community rehabilitation programmes, covering stroke, hip fracture and post-acute myocardial infarction. These programmes target at individuals discharged from public hospitals who have suffered from the three diseases. With referrals by HA or NMPs and upon joining K&TDHC as members, individualised rehabilitation plans are drawn up to facilitate them to prevent or reduce the impact of medical conditions and build up a healthier lifestyle under the relevant rehabilitation programmes.

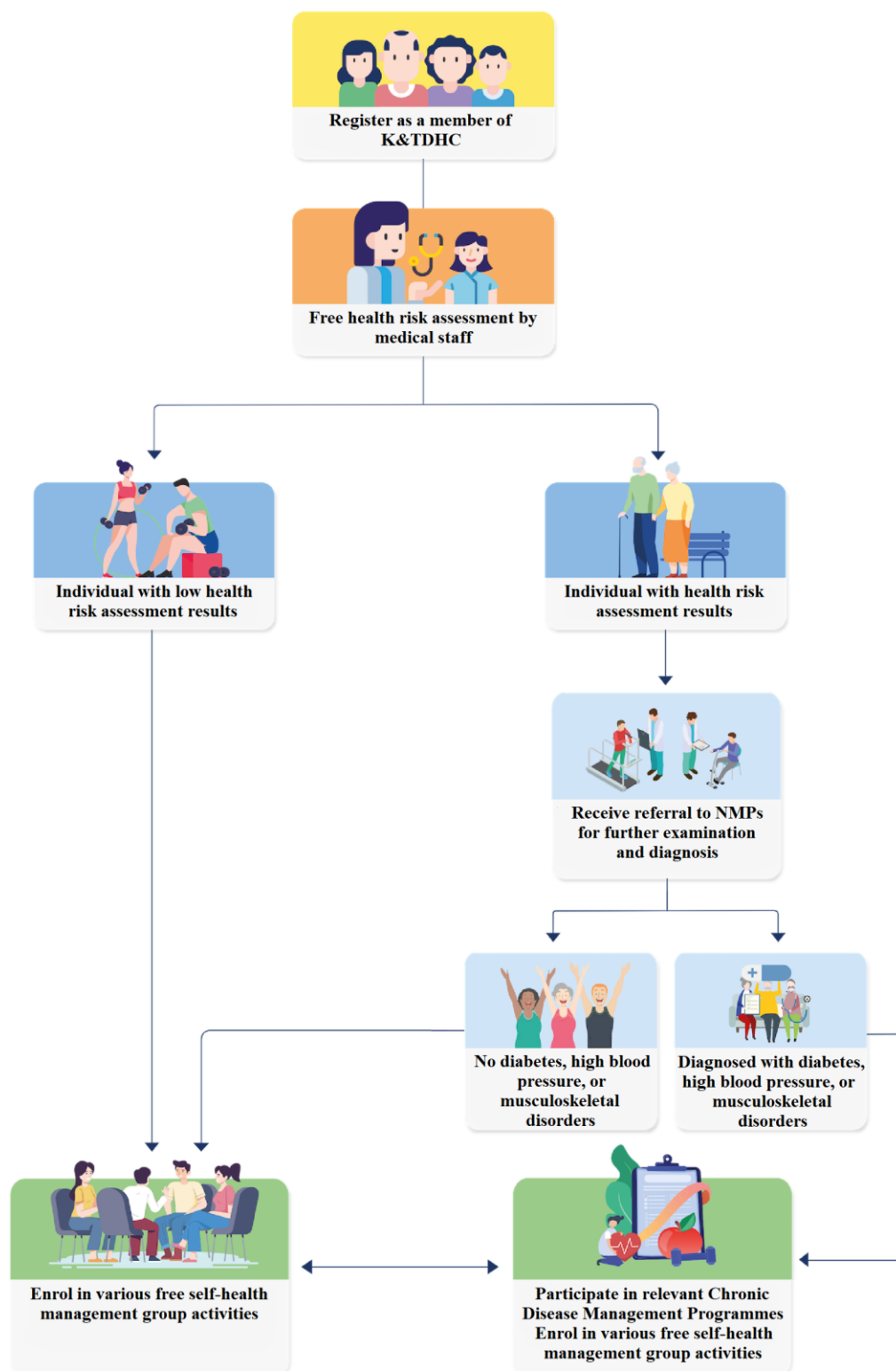
Under these programmes, members may be eligible to attend individual healthcare service sessions (e.g. physiotherapy and dietetics) provided by NSPs or in K&TDHC (i.e. by in-house healthcare professionals) at a subsidised rate of \$150 or \$100 per session (Note 15). The types of allied health services and the maximum number of subsidised sessions differ across the programmes. Details are shown at Appendix D.

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**Note 15:** *The co-payment by members is generally capped at \$150. The co-payment by members referred by HA for community rehabilitation programmes is capped at \$100.*

Figure 2

Client journey at K&TDHC



Source: K&TDHC records

## **Performance management**

2.5 PHO of HHB is responsible for monitoring the performance of DHC operators (see para. 1.7). Operator A is accountable to PHO for the operation and performance of K&TDHC, and is required to comply with the service contract, and observe the DHC Service Manual and Guidelines (hereinafter referred to as DHC Manual — see para. 3.11(b)) issued by PHO, which sets out, among others, the expectations on DHC operators and the DHC network.

### ***Room for improvement in attaining service output targets***

2.6 In each tender exercise for the operation of a DHC, the Government had set out in the tender document service output target(s) on the attendance for each level of prevention services. Potential operators could propose service volume which exceeded the government requirements, with justifications and explanations on how to achieve such targets. The proposed targets which the operator had undertaken to strive to achieve, upon the Government's acceptance, formed part of the service contract. The attainment of such targets would be taken into account in assessing the operator's overall performance. For K&TDHC, Operator A had proposed service outputs in excess of the government requirements for 6 of the 9 service output targets. Audit analysed K&TDHC's attainment of the service output targets (see Table 2) and noted that:

- (a) for 2019-20 (since its commencement on 17 September 2019), K&TDHC failed to attain all 9 targets, with the performance on 8 of them significantly below the targets (i.e. achieved less than 25% of the targets, ranging from 0% to 20%) and government requirements;
- (b) the situation generally improved in 2020-21. The target on primary prevention was over-achieved by 50%. However, K&TDHC still failed to attain 8 out of the 9 targets and government requirements. In particular, all of the 6 targets on tertiary prevention were significantly under-achieved (i.e. actual attainment ranging from 0% to 24%); and
- (c) the situation further improved in 2021-22 after adopting a revised classification of the activities (see para. 2.10), with 5 of the 9 targets over-achieved by 2% to 213%. However, 4 of the 9 targets (i.e. 1 of the 2 targets on secondary prevention and 3 of the 6 targets on tertiary prevention) were still under-achieved (i.e. actual attainment ranging from 50% to 92%).

## Provision of services by the Kwai Tsing District Health Centre

**Table 2**

**Attainment of service output targets  
(17 September 2019 to 31 March 2022)**

Service	Annual target		Actual		
	Government requirement	Proposed and accepted	2019-20 (since 17 September 2019) (Note 1)	2020-21	2021-22 (Note 2)
			(Attendance)		
<i>Primary prevention</i>					
Health promotion	20,000	28,125	9,009 (55 %)	42,066 (150 %)	46,758 (166 %)
<i>Secondary prevention</i>					
Basic health assessment	20,000	24,750	2,828 (20 %)	12,321 (50 %)	15,991 (65 %)
Screening for DM/HT (Note 3)	4,000	4,500	159 (6 %)	3,831 (85 %)	8,001 (178 %)
<i>Tertiary prevention</i>					
<i>Chronic disease management</i>					
DM	22,400	6,750	7 ( ~ 0 %)	75 (1 %)	5,253 (78 %)
HT		18,000	1 ( ~ 0 %)	3 ( ~ 0 %)	9,015 (50 %)
Musculoskeletal disorders	9,600	11,250	290 (4 %)	2,747 (24 %)	10,297 (92 %)
<i>Community rehabilitation</i>					
Stroke	1,650	1,650	39 (4 %)	326 (20 %)	1,687 (102 %)
Hip fracture	800	800	10 (2 %)	154 (19 %)	892 (112 %)
Post-acute myocardial infarction	320	320	16 (9 %)	64 (20 %)	1,002 (313 %)
<i>Vaccination (Note 4)</i>					
Influenza	N.A.	N.A.	N.A.	1,194	371
COVID-19	N.A.	N.A.	N.A.	N.A.	10,351

Source:      Audit analysis of HHB and K&TDHC records

**Table 2 (Cont'd)**

- Note 1: The attainment for the period is calculated on a pro-rata basis, i.e. 7 months for 2019-20 (since 17 September 2019).*
- Note 2: According to HHB, starting from 1 April 2021, a revised classification of DHC activities was adopted (see para. 2.10(a)). The attendance figures might not be comparable among different reporting periods.*
- Note 3: Apart from the subsidised medical consultations and/or laboratory tests by NMPs (see para. 2.4(b)(ii)), the “Screening for DM/HT” figures also included nurse counselling sessions provided by in-house nurses of K&TDHC.*
- Note 4: There was no service output target set for vaccination programmes in the service contract. In September 2022, HHB informed Audit that the service outputs of the vaccination programmes were counted towards the attainment of targets under tertiary prevention (see para. 2.10(b)).*

*Remarks: The percentage in bracket represents the attainment of the proposed and accepted target.*

2.7 According to HHB, it has been closely monitoring the achievement of service standards of K&TDHC through continuous reviews and discussions in committees and with Operator A, and also the control measures and reporting mechanism (see paras. 2.36 and 2.37). Audit noted that a letter was issued by PHO on 25 August 2020, in which concerns were raised on human resources management (see para. 3.4), financial management and administration of K&TDHC (Note 16). However, the significant under-achievement of the service output targets was not mentioned. Regarding the under-achievement, HHB informed Audit in August and September 2022 that:

- (a) in medical services, it was more appropriate to prioritise quality over quantity. Furthermore, in the past few years since K&TDHC commenced operation, services were disrupted due to social unrest and the COVID-19 epidemic. During the epidemic, K&TDHC was required by PHO to cease or limit

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**Note 16:** *In response to the letter, Operator A reported to PHO in September 2020 that it had conducted a thorough and extensive internal review of the concerns raised. According to Operator A, the service operation of K&TDHC was in compliance with most of the guidelines and procedures issued by PHO. Due to the social unrest situations in 2019 and the COVID-19 epidemic in 2020, some of the direct clinical services were put on hold or not implemented in full scale. In December 2020, Operator A further expressed its difficulties in a correspondence to PHO. For example, regarding the turnover and period of vacancy of the key personnel (see para. 3.4), with K&TDHC being the first of its kind (i.e. the first DHC), it would require a teething period and an adaptation to a community-based social/medical model.*



face-to-face and walk-in services in order to reduce the risk of community transmission. K&TDHC also took up additional tasks to fight against the epidemic (see para. 1.17);

- (b) it took time for the Government to work with the operator to ensure that the service model was evidence-based for service quality and better patient outcome. It also took time to promote the brand new service model to the public and shift the people's mindset from treatment-oriented to prevention-focused; and
- (c) the anti-epidemic work had compromised K&TDHC's capacity in the provision of the original core services. As a result of the COVID-19 epidemic (which started in early-2020, i.e. four months after the commencement of K&TDHC) and the implementation of anti-epidemic measures to support the Government to fight against COVID-19 (Note 17), some of K&TDHC's core functions in the three levels of primary healthcare prevention were to a certain extent affected (see para. 1.17). For example, K&TDHC temporarily suspended all on-site group/class activities to minimise crowd gathering from mid-January to end-May 2022. During the period of suspension, online education, individual assessment/consultation/therapy sessions and rehabilitation services were provided. The service adjustments had negatively affected its attainment of the service output targets.

2.8 According to K&TDHC, factors affecting its performance included the following:

- (a) the DHC Scheme operated under a brand new service model and it had operated for only two and a half years as of March 2022. It took time to try out the delivery model, to review and fine-tune the operation according to public feedback and difficulties encountered. It also took time to promote the services, recruit members and collaborate with relevant parties (e.g. HA and NGOs for case referrals). It was too early to collect the data for performance assessment;

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**Note 17:** *According to HHB, the anti-epidemic work provided by K&TDHC included distributing over 14,000 COVID-19 test bottles, some 175,000 anti-epidemic bags, around 464,000 rapid antigen test kits and over 3.2 million masks, participating in the COVID-19 vaccination programme, and providing outreaching and support services to the public (e.g. prepared multilingual pamphlets and organised online anti-epidemic education sessions).*

- (b) during the first two years of operation, social unrest and COVID-19 had seriously affected the service performance. It encountered tremendous obstacles and challenges since January 2020. For example, due to the social distancing measures, K&TDHC suspended face-to-face services/classes/talks to members in some months in 2020 and 2022. This had resulted in service output targets not met, in particular for secondary and tertiary prevention services because these services required face-to-face contacts with members. The impact of the COVID-19 epidemic has still been affecting the normal operation and the service outputs; and
- (c) due to the ad-hoc and urgent duties assigned by PHO during the COVID-19 epidemic (e.g. operated as a vaccination centre in February to May 2022 — see para. 1.17), it could not provide normal DHC services to the public.

2.9 Audit noted that for DHCEs (see para. 1.15), the contracts awarded in April 2021 (see para. 4.9) stipulated that if the calculated overall performance was lower than the yearly agreed service output targets, the Government had the right to deduct a percentage of an instalment payment (i.e. percentage of deduction depends on the attainment percentage of the yearly agreed service output targets — see para. 4.13). However, similar clauses were not included in the service contracts for the full-fledged DHCs (including the latest contract for Tsuen Wan DHC awarded in May 2022 — see Table 9 in para. 4.2). While noting the impact brought about by the COVID-19 epidemic and the service adjustments, with the resumption of normal DHC services, HHB needs to continue to closely monitor K&TDHC's attainment of service output targets and take further measures to enhance its performance (e.g. considering the need to incorporate a performance-based payment schedule in future DHC contracts).

### ***Need to clearly and timely specify service output targets for performance monitoring***

2.10 In examining the attainment of service output targets of K&TDHC (see Table 2 in para. 2.6), Audit noted that there were changes in the categorisation of the services under tertiary prevention, as follows:

- (a) ***Non-co-payment services under tertiary prevention.*** For the chronic disease management programmes and community rehabilitation programmes, members may be eligible to attend subsidised individual healthcare services provided by NSPs (e.g. Chinese medicine services) or in-house healthcare professionals

(e.g. dietetics sessions) under the co-payment arrangements (see para. 2.4(c)). Some services provided to members in the chronic disease management programmes and community rehabilitation programmes were free of charge (i.e. non-co-payment), including group-based classes (e.g. exercise classes and health information sessions) and face-to-face or remote counselling/follow-up sessions. According to HHB:

- (i) ***Before April 2021.*** Since its commencement in September 2019 and up to March 2021 (i.e. the first two reporting periods), only the co-payment sessions were included for performance reporting purposes. In other words, the tertiary prevention services only included the subsidised individual healthcare services under the co-payment arrangements; and
- (ii) ***From April 2021.*** Starting from April 2021, non-co-payment services (e.g. group-based classes) were also counted in the achievement of targets. For 2021-22, such non-co-payment services accounted for 83% and 63% of the reported attendances for the chronic disease management programmes and the community rehabilitation programmes respectively.

In this connection, Audit noted that the above change in the categorisation of tertiary services was included in DHC Manual only in February 2022 (see para. 3.11(b)); and

- (b) ***Vaccination programmes.*** HHB informed Audit in September 2022 that at a meeting of K&TDHC Executive Committee (see para. 1.8(b)) held in August 2022, it was agreed to recognise the service outputs of the vaccination programmes (including influenza and COVID-19 vaccination) under tertiary prevention. Hence, the related service outputs were counted towards the attainment of the tertiary prevention targets in the reporting periods of 2020-21 and 2021-22 retrospectively.

2.11 According to PHO, as the DHC Scheme is still new and evolving, it has been developing standards and targets for DHC services based on evidence and data. PHO and the operators have constantly been reviewing and enhancing the collection and reporting of data through reviewing and updating data categorisation, data collection and reporting template.

2.12 To avoid confusion, maintain comparability and facilitate performance monitoring, HHB needs to clearly and timely specify the service output targets in DHC Manual in case there are further changes to DHC services or the definition of the targets upon review.

### ***Need to consider disclosing service output targets and their attainment***

2.13 From time to time, there were questions from Members of the Legislative Council and the media on the achievement of DHCs. Audit noted that HHB did not make available information on the service output targets and DHCs' attainment of the targets to the public. Upon enquiry, HHB informed Audit in August 2022 that the targets and the attainment were monitored and reported routinely to the Governing Committees which comprised members from the community (see para. 1.8(a)). To further improve transparency and accountability, HHB needs to consider disclosing the service output targets and the attainment of DHCs to the public.

## **Audit recommendations**

2.14 **Audit has *recommended* that the Secretary for Health should:**

- (a) **continue to closely monitor K&TDHC's attainment of service output targets and take further measures to enhance its performance (e.g. considering the need to incorporate a performance-based payment schedule in future DHC contracts);**
- (b) **clearly and timely specify the service output targets in DHC Manual in case there are further changes to DHC services or the definition of the targets upon review; and**
- (c) **consider disclosing the service output targets and the attainment of DHCs to the public.**

## Response from the Government

2.15 The Secretary for Health agrees with the audit recommendations. He has said that:

- (a) the attainment of service output targets had seen gradual improvement in all service areas over the past three years, with over 100% achievement in primary and tertiary prevention services as well as screening for secondary prevention most recently; and
- (b) HHB will continue to closely monitor and work with K&TDHC on the attainment of service output targets, and will implement the audit recommendations in the context of taking forward the Primary Healthcare Blueprint making use of the DHCs/DHCEs as the hubs for coordinating primary healthcare services.

## Service delivery

### *Need to step up efforts in collaborating with other primary healthcare service providers*

2.16 Audit analysed the number of K&TDHC members up to 31 March 2022 (24,706 members in total) by recruitment sources and noted that:

- (a) 15,340 (62.1%) members joined K&TDHC by self-referral (i.e. walk-in);
- (b) 9,071 (36.7%) members joined K&TDHC through outreach activities;
- (c) 222 (0.9%) and 55 (0.2%) members joined K&TDHC by referrals from HA and NMPs respectively; and
- (d) 18 (0.1%) members were referred by other sources (e.g. DHCEs).

2.17 K&TDHC holds collaboration meetings and engagement activities with stakeholders with an aim to establish a long-term cooperation and referral mechanism.

## Provision of services by the Kwai Tsing District Health Centre

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Since the commencement of K&TDHC, the number of members referred by HA and NMPs has been on the low side (see para. 2.16(c)). Audit noted the following issues:

- (a) ***Stakeholders engagement forum.*** According to the service contract and DHC Manual, K&TDHC needs to organise a forum to gauge feedback from the community on DHC services by involving key stakeholders (e.g. allied health professionals and residents in the district). The forum should be held bi-annually. However, up to 31 March 2022, only 2 (instead of 5 as required) forums had been held. The number of NSPs attending the forums was on the low side. For example, in the first forum held in September 2020, invitations were sent to 87 NSPs but only 7 (8%) attended (Note 18);
- (b) ***Multi-disciplinary case conference meeting with NSPs.*** According to K&TDHC's business plan (see para. 2.36(a)), the objectives of the quarterly meetings were to identify or clarify issues/incidents regarding the logistics and workflow of various programmes, review progress and barriers towards the goals, resolve conflicts and formulate strategies on improving the workflow of K&TDHC. However, in 2021-22, only 2 meetings (instead of 4 as required) were held. Furthermore, against a target attendance of 15 NSPs, only 1 and 4 NSPs attended each meeting; and
- (c) ***DHC network focus group.*** According to K&TDHC's business plan, to maintain connections with NMPs, facilitate recruiting new comers through the sharing sessions and share new ideas, focus groups were planned to be held at least annually. Up to 31 March 2022, 4 focus groups were held in January, October and November 2021 and January 2022. However, no focus group was held in 2019 and 2020.

In Audit's view, HHB needs to remind K&TDHC to step up efforts in collaborating with other primary healthcare service providers with a view to promoting and further improving services (e.g. member referrals).

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**Note 18:** *According to PHO, fewer forums were held due to the need to maintain social distancing under the COVID-19 epidemic. As regards the attendance at the forums, according to K&TDHC, despite its efforts to invite NSPs to attend the forum by e-mails and telephone calls, some NSPs could not attend the forum due to busy schedule and the epidemic situation. Other than the forums, K&TDHC maintained close liaison with the NSPs on various occasions, such as stakeholder meetings, visits and telephone calls, newsletters and support to NSPs in using eHRSS.*

***Scope for improving attendance rates of group-based programmes***

2.18 K&TDHC organises group-based programmes under primary prevention and tertiary prevention. These services are provided at the core centre, the satellite centres and the service point. The service hours of:

- (a) the core centre are from 10 a.m. to 8 p.m. on Mondays to Wednesdays and Saturdays, and 10 a.m. to 9 p.m. on Thursdays and Fridays; and
- (b) the satellite centres and the service point are from 10 a.m. to 8 p.m. on Mondays to Saturdays.

2.19 The class size of the group-based programmes depends on the class nature. K&TDHC's internal guidelines further state that, for most types of the primary prevention programmes, the suggested minimum number of participants to conduct a class is 50% of capacity to enhance the facility utilisation and service efficiency (Note 19). For patient empowerment programmes under tertiary prevention, no minimum number of enrolment is set. Audit analysed the attendance records of group-based programmes conducted in September 2021 (see Table 3) and noted that:

- (a) a total of 701 classes were conducted with an average attendance rate of 77%;
- (b) of the 362 classes with a minimum number of enrolment set in the guidelines, enrolment of 136 (38%) classes did not comply with the guidelines. Audit's further analysis revealed that for 75 (11%) of the 701 classes, only one member enrolled in each class; and
- (c) for 32 (5%) classes held after 6 p.m. (i.e. after office hours), the average attendance rate was 95%, which was much higher than the overall attendance rate of 77%.

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**Note 19:** *According to HHB, DHC Manual does not set out any minimum requirement on enrolment of group-based programmes. DHC operators are welcome to have their internal guidelines or references to facilitate operation.*

Table 3

Attendance of group-based programmes  
(September 2021)

Type	Minimum no. of enrolment	No. of classes conducted	No. of classes with less than required minimum no. of enrolment	Average attendance rate (Note 1)
<b>Primary prevention</b>				
Exercise class	50% of capacity	156	52 (33%)	72%
Health education activity		168	61 (36%)	80%
DM/HT self-management programme	8	38	23 (61%)	89%
	Overall	362	136 (38%)	78%
<b>Tertiary prevention</b>				
Patient empowerment programme	N.A. (Note 2)	339	N.A.	77%
Group-based programme	Overall	701	N.A.	77%

Source: Audit analysis of K&TDHC records

Note 1: The attendance rate is calculated by:

$$(\text{No. of members attended} \div \text{No. of members enrolled}) \times 100\%$$

Note 2: No minimum requirement of enrolment is set.

2.20 According to PHO, in case of low enrolment, the mode of delivery could be adjusted to ensure effective provision of services (e.g. small group education as clinically indicated, or grouping members of similar classes into one class). In Audit's view, HHB needs to closely monitor K&TDHC's actions in improving the attendance rates of the group-based programmes, including offering more options for members (e.g. more after office-hour classes).



***Need to follow up members' attendance of annual health risk assessments timely***

2.21 Health risk assessments and screening are conducted for early identification of chronic diseases. According to the service contract, it is expected that members attend health risk assessments annually. According to K&TDHC, prior to membership anniversary, its staff make telephone calls to invite and encourage members to attend the assessments.

2.22 Audit examined K&TDHC records and noted that the percentage of members attending the annual health risk assessments upon membership anniversary was on the low side. For example, members registered in October 2020 were due to have annual assessments in October 2021. As of December 2021, only 9% of the members had attended the assessments (Note 20). Audit examined 10 members' case files and noted that in 7 (70%) cases, there were delays in conducting the annual assessments. Counting from one year after the first assessment, the delays ranged from 52 to 148 days (averaging 126 days). Besides, in 2 (20%) other cases, while the members did not show up for the appointments, no records were available showing that K&TDHC had followed up with the members concerned. To facilitate follow-up actions on members' health, HHB needs to closely monitor K&TDHC's actions in ensuring that members attend annual health risk assessments timely.

***Need to make further efforts in improving enrolment rates of screening programmes***

2.23 After attending the health risk assessments, members identified with high risk factors for DM/HT are referred to NMPs for further assessment and screening (screening programmes — see para. 2.4(b)(ii)). The enrolment rates measure the proportion of such members enrolling in the screening programmes after being referred, so that their health conditions can be followed up. Audit analysed the enrolment records of the screening programmes of such members (see Table 4) and noted that:

- (a) for the period 17 September 2019 to 31 March 2022, the overall enrolment rates were 58% for DM and 41% for HT respectively; and

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**Note 20:** *According to K&TDHC, some members refused to attend the annual health risk assessments in person because of the COVID-19 epidemic.*

## Provision of services by the Kwai Tsing District Health Centre

- (b) the enrolment rates for both programmes had been on an increasing trend, from 18% in 2019-20 to 69% in 2021-22 for DM, and from 5% to 85% for HT during the same period.

**Table 4**

**Enrolment rates of screening programmes  
(17 September 2019 to 31 March 2022)**

Programme	2019-20 (from 17 September 2019)	2020-21	2021-22	Overall
<b>DM</b>				
No. of members referred (a)	183	1,673	1,579	3,435
No. of members enrolled (b)	33	865	1,086	1,984
Enrolment rate (c) = (b) ÷ (a) × 100 %	18 %	52 %	69 %	58 %
<b>HT</b>				
No. of members referred (d)	66	120	125	311
No. of members enrolled (e)	3	20	106	129
Enrolment rate (f) = (e) ÷ (d) × 100 %	5 %	17 %	85 %	41 %

*Source: Audit analysis of HHB and K&TDHC records*

*Remarks: This table shows the number of members being referred and enrolled in the screening programmes, while Table 2 in paragraph 2.6 shows the number of attendance. In general, during the screening process, a member would attend two medical consultation sessions, one medical laboratory test and a few non-co-payment sessions at the DHC (e.g. for nurse counselling and making appointments for medical consultations).*

2.24 To ascertain the reasons for not enrolling in the screening programmes, K&TDHC made enquiries with members. The results indicated that, for members who did not enrol in the screening programmes upon attending the health risk assessments in

July to December 2021, 46% of the members preferred to be followed up by HA (Note 21).

***Need to make further efforts in improving enrolment rates of tertiary prevention programmes***

2.25 Chronic disease management programmes are provided to members who are diagnosed with DM/HT in the screening programmes, or those referred by NMPs to join the programmes including those with low back pain and osteoarthritic knee pain. As for the community rehabilitation programmes, members are referred by HA or NMPs. The enrolment rates of the tertiary prevention programmes are shown in Table 5. Audit noted that:

- (a) there was room for improvement in enhancing the enrolment rates of the community rehabilitation programmes, in particular the Hip Fracture Rehabilitation Programme (31%). Audit noted that K&TDHC had enquired members of their reasons for not joining the programmes, and the results indicated that for the period 1 July 2021 to 31 December 2021, 31% of members considered their conditions stable, and another 24% were not interested or preferred not to enrol (e.g. due to the COVID-19 epidemic) (Note 22); and

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**Note 21:** *For other members:*

- (a) 33% were not interested;
- (b) 16% provided some other reasons (e.g. preferred to be followed up by own private doctors or under consideration); and
- (c) 5% did not provide a reason or were unreachable.

**Note 22:** *For other members:*

- (a) 19% joined programmes organised by other service providers;
- (b) 10% were re-admitted to hospitals;
- (c) 10% provided some other reasons (e.g. need to arrange escort service); and
- (d) 6% did not provide a reason or were unreachable.

*To address the escort issue, K&TDHC arranges free point-to-point transportation service for members of the community rehabilitation programmes on a need basis.*

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- (b) for the chronic disease management programmes, the enrolment rates of the Low Back Pain Management Programme and Osteoarthritic Knee Pain Management Programme were over 100% (i.e. the number of members enrolled exceeded the number of members referred). Upon enquiry, K&TDHC informed Audit in August 2022 that in some cases, one referral was made for a member to participate in more than one programme. For example, if one referral was made for a member diagnosed with both low back pain and osteoarthritic knee pain to enrol in two programmes, the referral would only be counted either in the Low Back Pain Programme or the Osteoarthritic Knee Pain Management Programme. In Audit's view, the referral should be counted in both programmes in calculating the enrolment rates.

**Table 5**

**Enrolment rates of tertiary prevention programmes  
(17 September 2019 to 31 March 2022)**

Programme	No. of members		Enrolment rate (c) = (b) ÷ (a) × 100%
	Referred (a)	Enrolled (b)	
Chronic disease management programme			
DM	152	149	98%
HT	22	19	86%
Low back pain	487	518	106%
Osteoarthritic knee pain	503	549	109%
Community rehabilitation programme			
Stroke	224	136	61%
Hip fracture	317	98	31%
Post-acute myocardial infarction	78	65	83%

*Source: Audit analysis of HHB and K&TDHC records*

*Remarks: Figures in this table show the number of members being referred and enrolled in the programmes, while Table 2 in paragraph 2.6 shows the number of attendance. Under tertiary prevention programmes, the number of sessions attended depends on the clinical needs and the maximum number of sessions subsidised by the Government (see para. 2.4(c) and Appendix D).*

2.26 In Audit's view, to ensure that members' conditions can be managed through the programmes, HHB needs to continue to monitor K&TDHC's actions in enhancing the enrolment rates of its screening programmes and tertiary prevention programmes, taking into account members' feedback (e.g. step up efforts to promote the benefits of its programmes and offer more online programmes). HHB also needs to ensure that referrals involving multiple tertiary prevention programmes are properly accounted for in calculating the enrolment rates of the programmes.

## **Audit recommendations**

2.27 **Audit has recommended that the Secretary for Health should:**

- (a) **remind K&TDHC to step up efforts in collaborating with other primary healthcare service providers with a view to promoting and further improving services (e.g. member referrals);**
- (b) **closely monitor K&TDHC's actions to improve service delivery, including:**
  - (i) **improving the attendance rates of the group-based programmes, including offering more options for members (e.g. more after office-hour classes);**
  - (ii) **ensuring that members attend annual health risk assessments timely; and**
  - (iii) **enhancing the enrolment rates of the screening programmes and tertiary prevention programmes; and**
- (c) **ensure that referrals involving multiple tertiary prevention programmes are properly accounted for in calculating the enrolment rates of the programmes.**

## **Response from the Government**

2.28 The Secretary for Health agrees with the audit recommendations.

## Management of network services

### *Need to step up efforts in ensuring compliance with requirements relating to DHC network*

2.29 NSPs (including NMPs) are engaged by a DHC operator to provide screening and individual healthcare services in the district concerned to form a DHC network in an open and fair mechanism. The service contract and DHC Manual stipulate the operator's roles on the management of the DHC network. The list of NSPs is proposed by the operator and needs to be approved by PHO (Note 23). Upon approval, the operator should arrange NSPs to sign an agreement (DHC network agreement), specifying the terms and conditions of the DHC Scheme which they should accede to and comply with. Audit examined the DHC network records of K&TDHC and noted instances of non-compliance.

2.30 *Non-compliance of NSPs.* Audit noted the following issues:

- (a) *NSPs not enrolled in eHRSS.* According to the service contract, NSPs should enrol in and upload onto eHRSS all records of use of the network services by DHC members. On 31 May 2022, K&TDHC website showed that there were 131 NSPs in its DHC network (Note 24). However, according to K&TDHC records, 3 (2%) of the 131 NSPs (including the only physiotherapist and the only occupational therapist in the Kwai Tsing District) were not yet ready to use eHRSS as at 31 May 2022 (i.e. after joining the DHC network for 2 to 2.5 years). As a result, the 3 NSPs could not provide services to K&TDHC's members;
- (b) *Withdrawals with late notifications.* To minimise service disruption, in accordance with the DHC network agreement, should NSPs wish to terminate the agreement, they should serve a notice to Operator A in writing at least

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**Note 23:** *According to PHO, a DHC operator shall maintain updated records on NSPs. PHO also keeps a list of approved NSPs and updates the information when the DHC operator notifies PHO of any changes. As one of the eligibility requirements of NSPs, all NMPs and Chinese medicine practitioners must appear on the Primary Care Directory of HHB (see Note 4 to Appendix A). PHO will notify the DHC operator an NMP/Chinese medicine practitioners' failure to meet the maintenance requirement of the Primary Care Directory (e.g. delisted by the corresponding statutory boards/councils).*

**Note 24:** *Of the 131 NSPs, 38 were in the Kwai Tsing District and 93 were in adjoining districts (i.e. Tsuen Wan, Sham Shui Po, Sha Tin and Central).*

90 days in advance. Audit found that, up to 31 March 2022, 18 (82%) of the 22 withdrawals had not fulfilled the notice period requirement. The delays ranged from 4 to 124 days (averaging 70 days). For example, in 7 cases, the withdrawals were with immediate effect upon notification; and

- (c) ***Claims for reimbursement not timely submitted.*** According to the DHC network agreement, NSPs shall submit to the operator claims for reimbursement regarding services provided to DHC members in the month through the DHC information technology (IT) system (Note 25) on the third working day of the following month. Audit noted from K&TDHC's records of outstanding payments to NSPs that, as at 31 March 2022, there were 121 long outstanding payments (i.e. remained unsettled for over 6 months — ranging from 7 to 27 months, averaging 14 months) and involving a total of some \$33,000. Upon enquiry, K&TDHC informed Audit in July 2022 that this could be due to the NSPs not submitting the claims for reimbursement timely.

2.31 DHC Manual stipulates the requirements regarding management of NSPs by DHC operators, including setting up internal control procedures and guidelines on monitoring NSPs. In March 2021, K&TDHC drew up an action plan and aimed to conduct on-site visits to all NSPs in the DHC network at least once and as necessary by March 2022. During these visits, it would collect direct feedback, deliver training, and assess quality and service compliance. According to K&TDHC, up to 31 March 2022, it had conducted 6 on-site visits. However, it could not provide inspection records for 3 (50%) of the visits.

2.32 ***Non-compliance of Operator A.*** Audit noted that:

- (a) ***Required number of NSPs not met in some categories.*** The service contract stipulated the minimum number required for each type of NSPs. Audit noted that as at 31 March 2022, while the minimum number of dietitians required was 3, only 1 network dietitian was engaged;

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**Note 25:** *The DHC IT system is provided by HHB to support the administrative, financial and clinical workflow of DHCs and NSPs. It facilitates the provision of clinical services by NSPs to members, which includes clinical documentation, attendance registry, clinical record sharing and subsidy claims submission. The system is connected to eHRSS to facilitate sharing of health records. DHC operators and NSPs should ensure proper documentation of essential data in the system.*

- (b) ***DHC network statements not submitted according to stipulated timeframe.*** For reimbursement of network subsidy, the operator should submit to PHO within 15 days after the end of each month (up to February 2022 — Note 26) a Network Medical and Healthcare Practitioners Statement (DHC network statement), showing the amount of network subsidy paid by the operator to NSPs for the relevant month. For the period from December 2019 to March 2022, 27 monthly DHC network statements were due for submission (Note 27). Audit noted that in practice, K&TDHC submitted the claims of the same month in batches (ranged from 1 to 10 batches) that spanned over a period of time (i.e. instead of submitting claims in one statement according to the stipulated timeframe of 15 days). The time elapsed between the due dates of statements and the submission of the last batch of claims ranged from 5 to 466 days (averaging 183 days); and
- (c) ***Inaccurate NSP information on website.*** The operator should always maintain an updated list of NSPs (Note 28) with full names, qualifications, practice addresses and opening hours, and the amount of members' co-payment per session for each NMP under the co-payment arrangement. The list should be made available for members' information and choice through its website and displaying hardcopies in the centres and all service points of all NMPs. According to K&TDHC, since November 2020, the list of NSPs on its website has been updated on the 8th of each month. Based on the information of NSPs

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**Note 26:** *The timeframes for the submission of DHC network statements and reports/plans (see Note 31 to para. 2.41) are stipulated in DHC Manual, which was updated in February 2022 (see para. 3.11(b)). When analysing the timeliness of the submission of the statements and reports/plans, applicable timeframes had been used. Up to February 2022, the timeframe for submission of DHC network statements was 15 calendar days after the end of each month, and revised to 12 working days after the end of each month with effect from March 2022.*

**Note 27:** *According to PHO, NSPs have provided services since December 2019.*

**Note 28:** *According to PHO, to ensure that the DHC operator can keep up a good practice on ensuring the completeness, accuracy and consistency of the basic information of NSPs, the operator is required to conduct a yearly check on the validity and eligibility of NSPs, such as the registration with healthcare related statutory boards and councils, membership of professional organisations, and the expiry of practicing certificates applicable to the respective professions. The checking results will be shared to PHO in joint meetings as and when appropriate. PHO will also conduct an annual check on the list of NSPs on the dedicated website of the DHC (see para. 4.26) against the updated approved record and the information shown on the Primary Care Directory. PHO will provide observations with recommended actions to the operator for follow-up as appropriate.*



on K&TDHC website as at 30 November 2021, Audit made anonymous telephone enquiries to 30 NSPs on 30 November 2021. According to the NSPs:

- (i) a Chinese medicine practitioner no longer provided services in the clinic listed on K&TDHC website;
- (ii) another Chinese medicine practitioner would cease providing services in the clinic listed on K&TDHC website in mid-December 2021. Audit made follow-up enquiries on 31 January 2022 and 31 May 2022 and noted that the practitioner no longer provided services in the clinic; and
- (iii) a speech therapist only provided services on Sundays, instead of on Mondays to Saturdays as shown on K&TDHC website. Audit made a follow-up enquiry on 31 May 2022 and noted that the therapist no longer provided services in the clinic listed on the website.

Further to the enquiries with the NSPs, Audit checked the list of NSPs on K&TDHC website as at 31 May 2022 (i.e. 6 months after the telephone enquiries) and noted that the 3 NSPs were still on the list.

2.33 According to K&TDHC, some of the factors deterring the collaboration with private healthcare service providers to join as NSPs included complicated procedures, long waiting time for enrolling in eHRSS, and using eHRSS (e.g. recording attendance and submitting claims). In view of the Audit observations, HHB needs to step up monitoring of K&TDHC's compliance with the requirements in relation to the management of network services and provide assistance to address related issues as appropriate.

### **Audit recommendation**

2.34 **Audit has *recommended* that the Secretary for Health should step up monitoring of K&TDHC's compliance with the requirements in relation to the management of network services and provide assistance to address related issues as appropriate.**

## Response from the Government

2.35 The Secretary for Health agrees with the audit recommendation.

## Service and financial monitoring

2.36 *Service monitoring.* According to PHO, service data analyses and reporting are key means to monitor the performance and service quality of the DHC Scheme. The service monitoring mechanism includes:

- (a) *Annual business plan.* Operators are required to submit an annual business plan to the Governing Committee (see para. 1.8(a)) setting out plans to carry out the services and ways to achieve service output targets for approval by PHO;
- (b) *Submission of reports.* Operators are required to submit annual reports and monthly service reports within a specified timeframe. The service reports (Note 29) are reviewed and discussed between PHO and the operator in the Executive Committee (see para. 1.8(b)), and quarterly reports are submitted to the Governing Committee for guidance and advice;
- (c) *Inspection visits (service inspections).* PHO conducts inspection visits to DHCs. Operators are required to conduct internal audits and report to PHO as and when necessary. Within PHO, different internal procedures are developed for staff to monitor the operators; and
- (d) *Deliberations by committees.* According to HHB, service outputs and quality are deliberated and reviewed by the Executive Committee, Governing Committee and the Steering Committee.

2.37 *Financial monitoring.* According to PHO, ensuring compliance with the set of financial and accounting requirements by the operators is essential to support the sound financial management of the DHC Scheme. The financial monitoring mechanism includes:

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**Note 29:** *According to the service contract, the monthly service reports cover aspects including progress of enrolment, number of attendance, service sessions and programmes delivered, and explanations for failure to meet any of the service requirements.*

- (a) ***Annual budget.*** Operators are required to submit an annual budget for the forthcoming financial year with projections on income and expenditure for the endorsement of the Governing Committee and approval by PHO before the start of the financial year;
- (b) ***Submission of financial reports.*** Operators are required to submit monthly income and expenditure statements, and annual financial statements with auditor's reports (issued by external auditors) in respect of DHC services and audited financial statements of the operators as a whole; and
- (c) ***Inspection visits (financial inspections).*** PHO conducts inspection visits to evaluate the adequacy and effectiveness of the operators' internal control systems, and assesses whether the operators have complied with the requirements laid down in the service contract, guidelines (e.g. DHC Manual) and PHO's instructions on financial and procurement matters.

### ***Need to take timely actions after inspections***

2.38 According to PHO, after a service or financial inspection, PHO would seek the operator's clarifications and provide advice on irregularities identified through verbal and written communication for its immediate follow-up. A summary of the observations and recommendations for improvements on areas requiring special attention (inspection summary) would be issued to the operators. Operators are invited to provide comments on the areas raised by PHO and a summary of remedial actions to prevent recurrence of similar issues.

2.39 ***Need to take timely actions to rectify deficiencies.*** Up to 31 March 2022, PHO had conducted 3 service inspections and 4 financial inspections to K&TDHC. Audit found that, for the 4 financial inspections, the time taken by PHO to issue inspection summaries to K&TDHC varied significantly (ranging from 82 to 385 days, averaging 263 days). In a financial inspection in August 2020, PHO found that Operator A had not maintained an interest-bearing account. PHO issued the inspection summary in July 2021 and Operator A took follow-up actions in September 2021 (i.e. more than a year after the deficiency was revealed in the inspection in August 2020 — Note 30). In Audit's view,

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**Note 30:** *In September 2021, Operator A deposited \$10 million to an interest-bearing account.*

HHB needs to remind DHC operators to take timely actions to rectify deficiencies identified in PHO's inspections.

2.40 *Need to expedite preparation of inspection guidelines.* Upon enquiry about the arrangements of PHO's inspections, PHO informed Audit in January 2022 that 1 to 2 visits of service inspections and 1 financial inspection would be conducted to a DHC each year. Relevant internal guidelines were under preparation. In Audit's view, HHB needs to expedite the preparation of the inspection guidelines, which should cover timeframes for issuing inspection summaries to operators.

### *Need to improve timeliness of submission of reports and plans*

2.41 According to the service contract and DHC Manual, operators shall submit certain reports and plans within specified timeframes (see paras. 2.36 and 2.37 — Note 31) for monitoring service performance. Since the commencement of K&TDHC and up to 31 March 2022, for the service/financial reports and plans, Audit found that:

- (a) of the 70 reports/plans submitted, 34 (49%) were late for over 3 days, with the delays ranging from 4 to 48 days (averaging 17 days); and
- (b) of the 34 delay cases, written reminders were issued on 25 (74%) occasions.

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**Note 31:** *Prior to March 2022, the timeframes for submitting the following reports/plans were:*

- (a) *monthly service report: 15 working days after the end of each month;*
- (b) *monthly income and expenditure statement: 15 days after the end of each month;*
- (c) *annual business plan/budget: 2 months before the start of the financial year;*
- (d) *annual report: 3 months after the end of each financial year; and*
- (e) *audited financial report: 4 months after the end of each financial year.*

*The submission timeframes of some of the reports/plans have been revised upon the updating of DHC Manual in February 2022 (see para. 3.11(b)). When analysing the timeliness of the submission of the reports/plans, applicable timeframes had been used.*

2.42 Upon enquiry, HHB informed Audit in August 2022 that:

- (a) DHC was a brand new service model and K&TDHC was developed as a pilot scheme as indicated in the 2017 Policy Address (see para. 1.5). As the DHC IT system (see Note 25 to para. 2.30) was newly developed and the services were evolving, there were limitations in the system in collecting data for all the service outputs. As a result, some data had to be manually captured;
- (b) it required a lot of deliberations and discussion with frontline staff on the service nature and data definition to ensure accurate capturing of service outputs. PHO took a collaborative approach and had continuous telephone conversations and meetings with the operator to understand its difficulties and concerns, and to align definitions and formats for all reports;
- (c) in view of the COVID-19 situation, service provision to members should be the top priority, and the clarifications of data definition and reports could be done later as agreed with the operator; and
- (d) written reminders and warnings would only be given for prolonged or repeated delays.

While noting HHB's explanations, in Audit's view, to facilitate performance monitoring, HHB needs to: (a) ensure that essential data can be captured by the DHC IT system to facilitate the preparation of reports and performance monitoring; and (b) continue to monitor K&TDHC's compliance with the submission deadlines of reports and plans stipulated in the service contract.

### ***Extension of service of K&TDHC***

2.43 The service contract for K&TDHC covers a three-year operation period from September 2019 to September 2022. According to the terms of the contract, the Government can extend Operator A's services for a maximum of 3 years by giving not less than 6 months' notice.

2.44 PHO noted that the performance of Operator A was unsatisfactory and that the service throughput was well below the agreed service output targets (see para. 2.6). As there was gradual improvement in the service statistics, HHB proposed to consider

extension of the service contract on a yearly basis, subject to the satisfactory performance of Operator A in the provision of services, and operation and administration of K&TDHC (Note 32). In Audit's view, HHB needs to closely monitor the performance of Operator A and take follow-up actions as appropriate.

### Audit recommendations

2.45      **Audit has *recommended* that the Secretary for Health should:**

- (a)      **remind DHC operators to take timely actions to rectify deficiencies identified in PHO's inspections;**
- (b)      **expedite the preparation of the inspection guidelines, which should cover timeframes for issuing inspection summaries to operators;**
- (c)      **ensure that essential data can be captured by the DHC IT system to facilitate the preparation of reports and performance monitoring;**
- (d)      **continue to monitor K&TDHC's compliance with the submission deadlines of reports and plans stipulated in the service contract; and**
- (e)      **regarding the extension of service of K&TDHC, closely monitor the performance of Operator A and take follow-up actions as appropriate.**

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**Note 32:** *In December 2021, PHO and Operator A agreed to extend the service contract for 12 months, i.e. until September 2023. According to PHO, in case Operator A did not show substantial improvement to the satisfaction of PHO, it might consider not further extending the contract, and start to prepare for re-tendering and transition in case a new operator has to be identified.*

## **Response from the Government**

2.46 The Secretary for Health agrees with the audit recommendations. He has said that:

- (a) HHB has prepared the financial inspection guidelines, including the timeframes for issuing inspection summaries to operators and actions required by the DHC operators to rectify the deficiencies identified in the inspections; and
- (b) HHB will consider the service extension of K&TDHC as appropriate, taking into account the refinement on the roles and functions of DHCs in the district-based primary healthcare system according to the Primary Healthcare Blueprint.

## **PART 3: ADMINISTRATIVE ISSUES OF THE KWAI TSING DISTRICT HEALTH CENTRE**

3.1 This PART examines the administrative issues of K&TDHC, focusing on:

- (a) human resources management (paras. 3.2 to 3.9);
- (b) procurement issues (paras. 3.10 to 3.19); and
- (c) promotion efforts (paras. 3.20 to 3.26).

### **Human resources management**

3.2 K&TDHC is managed by the Executive Director (overseeing the overall operation) and the Chief Care Coordinator (overseeing the clinical services) (see para. 2.3). There are two departments under the organisation structure of K&TDHC, namely the Care and Service Department which comprises staff providing healthcare services (e.g. care coordinators/registered nurses, allied health professionals and social workers) and the Administration and Finance Department (e.g. executive officers and accounting officers). According to PHO, the manpower situation of K&TDHC is reported monthly to PHO, and also reviewed in the meetings of Governing Committee and Executive Committee regularly (see para. 1.8(a) and (b)) where members of the committees will provide expert advice (e.g. for enhancing staff recruitment). As at 31 March 2022, K&TDHC's staff establishment and strength were 81 and 67 respectively (Note 33).

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**Note 33:** *Apart from the staff on the establishment, K&TDHC also employs short-term staff for ad-hoc tasks. For example, during the fifth-wave of the COVID-19 epidemic, nurses and other support staff were employed on a short-term basis for the provision of vaccination services (see para. 1.17(b)). Part-time staff are also employed as and when appropriate (e.g. difficulty in recruiting full-time staff). As at 31 March 2022, the total number of staff was 101, which included 29 short-term staff and 11 part-time staff.*



***Need to take measures to address high staff turnover***

3.3 Audit analysed the staff turnover of K&TDHC since its commencement and up to 31 March 2022 (see Table 6) and noted that the staff turnover rates increased from 50% in 2019-20 to 101% in 2021-22. In particular, the turnover rates for the Care and Service Department increased threefold from 41% in 2019-20 to 128% in 2021-22. Audit's further analysis revealed that the turnover for social workers was exceptionally high at 275% in 2021-22 (see also para. 3.6(b)).

**Table 6**

**Staff turnover of K&TDHC  
(17 September 2019 to 31 March 2022)**

	<b>2019-20 (since 17 September 2019)</b>	<b>2020-21</b>	<b>2021-22</b>
<b><i>K&amp;TDHC</i></b>			
No. of staff who left K&TDHC (a)	15	34	82
Average no. of staff (Note 1) (b)	30	67	81
Turnover rate (c)=(a)÷(b)×100%	50%	51%	101%
<b><i>Care and Service Department</i></b>			
No. of staff who left K&TDHC (d)	8	27	69
Average no. of staff (Note 1) (e)	19.5	46.5	54
Turnover rate (f)=(d)÷(e)×100%	41%	58%	128%
<b><i>Administration and Finance Department (Note 2)</i></b>			
No. of staff who left K&TDHC (g)	7	7	13
Average no. of staff (Note 1) (h)	10.5	20.5	27
Turnover rate (i)=(g)÷(h)×100%	67%	34%	48%

*Source:* Audit analysis of K&TDHC records

*Note 1:* The average number of staff is calculated by:

(No. of staff at the start of the period + No. of staff at the end of the period) ÷ 2

*Note 2:* The Executive Director oversees both departments. For the purpose of calculating staff turnover, the post is included in the Administration and Finance Department.

*Remarks:* Short-term staff were excluded from the analysis because of its ad-hoc nature.

## Administrative issues of the Kwai Tsing District Health Centre

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3.4 As stated in the service contract, the operator should deploy throughout the term key personnel (i.e. the Executive Director and the Chief Care Coordinator) to oversee the operation. Audit noted a very high turnover of the key personnel:

- (a) **Executive Director.** In the period from 4 March 2019 (Note 34) to 31 March 2022, 3 Executive Directors had resigned and each of them had served K&TDHC for a short period of time (ranging from 5 to about 7 months). The incumbent is the fourth Executive Director (who has served for over one year and three months as of August 2022). Besides, in some periods, the post of Executive Director was vacant, with the longest being 5 months; and
- (b) **Chief Care Coordinator.** During the same period, 2 Chief Care Coordinators had resigned and they had served K&TDHC for about 11 and 19 months respectively. The incumbent is the third Chief Care Coordinator (who was on acting appointment from August 2021 and officially appointed as Chief Care Coordinator in May 2022).

In this connection, in a letter dated 25 August 2020 issued to Operator A (see para. 2.7), PHO expressed serious concerns about the successive resignation of the key personnel within a short period of time, and opined that the repeated turnover was affecting service delivery of K&TDHC and reflected some fundamental issues in the ability in retaining staff in key positions.

3.5 According to K&TDHC, it had taken measures in an attempt to address the turnover issue, including:

- (a) conducting exit interviews to ascertain the reasons for resignation. Audit analysed the relevant records of August 2020 to March 2022 and noted that the top three reasons were career development (34%), remuneration and benefits (20%) and further study (9%);

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**Note 34:** *According to the service contract, a gearing up period of up to 8 months prior to the commencement date is allowed. During this period, the Executive Director and the Chief Care Coordinator are designated for administrative set up of K&TDHC, establishing system of office management (e.g. human resources and financial management) and liaising with related government departments and NSPs, etc.*

- (b) improving staff welfare by implementing a “five-day work week” arrangement since 1 August 2020, recruiting part-time healthcare workers to alleviate manpower shortage and workload, and reviewing regularly its staff remuneration package; and
- (c) providing staff development and training opportunities. For example, in 2020-21, it conducted 8 training sessions (e.g. on professional development and customer management).

In Audit’s view, HHB needs to closely monitor K&TDHC’s actions to improve human resources management, including reviewing the effectiveness of the measures to address the high staff turnover, and taking follow-up actions as appropriate with a view to maintaining sufficient manpower to provide quality services.

***Need to fulfill manpower requirement and  
address shortage of core staff***

3.6 To ensure that quality and comprehensive services are provided, the service contract has stipulated the minimum number of healthcare professionals and the essential services required. Also, the operator should deploy a team of core staff (Note 35) for the provision of services throughout the 3-year operation period. Audit found that the required numbers of staff were not met for some positions:

- (a) each satellite centre is required to be manned by one full-time nurse (Note 36). As at 31 December 2021, of the 5 satellite centres, only 3 met the requirement. For the remaining 2, each of them only had a part-time registered nurse; and

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**Note 35:** *The team of core staff comprises the Executive Director, Chief Care Coordinator, care coordinators, physiotherapists, occupational therapists, pharmacists, social workers, dietitians and some administrative staff. The Government set out the minimum number of core team staff (21 staff) and the operator could propose a higher number of staff than the minimum requirements. Operator A proposed and the Government agreed that 27 core team staff should be hired for K&TDHC.*

**Note 36:** *Each satellite centre should be manned by, in general, a registered nurse, 2 to 3 community health practitioners/assistants and a workman. According to K&TDHC Operations Manual (see para. 3.11(c)), the registered nurse has to provide health assessments, screening, counselling, health education, and other nursing services while community health practitioners/assistants provide assistance to the registered nurse.*

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- (b) K&TDHC should have 5 social workers in the core team (against government minimum requirement of 3). However, only 2 social workers were employed as at 31 March 2022.

According to K&TDHC, for the case of nurses at the satellite centres, due to high staff turnover, it recruited some part-time nurses as an intermediate arrangement to substitute vacancies. K&TDHC's senior care coordinators would assign job duties and also monitor their work and operation. Full-time nurses would be assigned to the satellite centres once available. As for the insufficient number of social workers, it was due to recruitment difficulty.

3.7 In Audit's view, to ensure service quality and avoid employee overload, HHB needs to closely monitor K&TDHC's compliance with the manpower requirements in the service contract.

### **Audit recommendations**

3.8 **Audit has *recommended* that the Secretary for Health should closely monitor:**

- (a) **K&TDHC's actions to improve human resources management, including reviewing the effectiveness of the measures to address the high staff turnover and taking follow-up actions as appropriate; and**
- (b) **K&TDHC's compliance with the manpower requirements in the service contract.**

## Response from the Government

3.9 The Secretary for Health agrees with the audit recommendations. He has said that:

- (a) the healthcare system of Hong Kong continues to face serious shortage in healthcare manpower which is being addressed separately through a host of policy measures; and
- (b) HHB will continue to closely monitor K&TDHC's actions to improve human resources management and explore progressively enhancing the role of other primary healthcare professionals in the delivery of DHC services.

## Procurement issues

3.10 According to the service contract, the operator should set up and monitor its own procurement and stores management system with appropriate records, adequate checks and control mechanism. Such system should be in line with that of the Government. The operator should strictly observe the government quotation requirements in making procurement with DHC funding. In addition, the operator shall provide the services in accordance with the stipulations set out in the service manual and guidelines that may be issued from time to time by the Government in relation to the DHC Scheme. In this regard, PHO has issued DHC Manual for adoption by DHCs, in which the guidelines are key references to be adhered to whenever practicable (see para. 2.5). A section of DHC Manual is related to financial management and payment mechanism (including procurement).

### *Need to ensure compliance with procurement guidelines*

3.11 Audit noted that there were three different sets of guidelines governing procurement matters of K&TDHC, as follows:

- (a) ***Operator A's Guidelines.*** The service contract was awarded to Operator A in March 2019 and covered a gearing up period of up to 8 months from the commencement date. Under the contract, Operator A had to procure goods and services to prepare the core centre (e.g. fitting out and setting up) to be in a state of readiness for the provision of services.

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Before PHO issued the first version of DHC Manual in September 2019 (see (b)), Operator A had adopted its own procurement guidelines (hereinafter referred to as “Operator A’s Guidelines”) on K&TDHC’s procurement matters;

- (b) ***DHC Manual.*** In September 2019, PHO issued a Service Manual and Guidelines for operation of K&TDHC (first version of DHC Manual). It did not set out detailed procedures on procurement matters, except that Operator A should:
- (i) draw up procurement guidelines of its own in line with the Stores and Procurement Regulations of the Government; and
  - (ii) seek Government’s prior agreement for any procurement with an estimated contract value exceeding \$50,000.

In September 2020, PHO issued the “DHC Service Manual and Guidelines”, which was applicable to all DHCs (second version of DHC Manual). It set out government minimum requirements on procurement, including procurement methods for goods and services of different values, such as the number of quotations or tender needed (see Table 7 in para. 3.13 and Note 37). The DHC Manual was updated in February 2022 and issued in March 2022 (third version of DHC Manual — see para. 3.17(b)). The procurement requirements were revised (e.g. removal of the need for Government’s prior agreement for any procurement with an estimated value exceeding \$50,000 (see para. 3.14(c)), and submission of a half-yearly audit report on procurement activities by DHC operators). According to PHO, the updates were based on feedback obtained from DHC operators and understanding gained from the financial inspections with a view to enhancing operational efficiency and for monitoring purpose. The latest version was issued in June 2022 (Note 38); and

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**Note 37:** *According to PHO, these requirements were referenced to procurement regulations of the Government as well as manuals of other government-funded services.*

**Note 38:** *During the audit review, Audit referred to the second version of DHC Manual issued in September 2020, which was applicable to the procurements made during the period under examination (see paras. 3.13 to 3.16).*

- (c) ***K&TDHC Operations Manual.*** In September 2021, K&TDHC issued a set of manual, entitled “K&TDHC Operations Manual”, which also covered procurement requirements. According to PHO, it elaborates with more details to fit the operational needs based on the requirements in DHC Manual and has adopted the operator’s more stringent procurement criteria for transactions involving larger sums.

3.12 Upon enquiry on the applicability of the three sets of guidelines, K&TDHC informed Audit in January 2022 that:

- (a) it should follow Operator A’s Guidelines issued in July 2019 (see para. 3.11(a));
- (b) it had been following the updated versions of DHC Manual issued by PHO (see para. 3.11(b)); and
- (c) an updated draft of K&TDHC Operations Manual (see para. 3.11(c)) had been prepared by Operator A in January 2022 based on the DHC Manual, comments from PHO and advice of the consultant of the monitoring and evaluation study (see para. 1.13) were being sought.

In this connection, Audit noted that PHO had referred to Operator A’s Guidelines and DHC Manual in conducting financial inspections (see para. 2.37(c)).

3.13 Audit noted that there were three sets of procurement guidelines applying to K&TDHC (see Table 7). Upon enquiry, HHB informed Audit in September 2022 that while DHC Manual set out the government minimum requirements for the operation of DHCs, HHB considered that the operators’ policies with more stringent requirements would be acceptable. However, audit examination revealed that this might have led to confusion and non-compliance with some of the guidelines (see paras. 3.14 and 3.15).

**Table 7**

**Procurement requirements for K&TDHC  
(31 December 2021)**

Financial limit of estimated value of goods and services of	Procurement requirement		
	Operator A’s Guidelines (see para. 3.11(a))	DHC Manual (see para. 3.11(b))	K&TDHC Operations Manual (see para. 3.11(c))
≤\$5,000	Competitive bidding is not required but should be made as far as possible (Note)	2 written quotations should be obtained as far as practicable except for urgent minor purchases	
> \$5,000 and ≤\$50,000	2 written quotations		
> \$50,000 and ≤\$200,000	5 written quotations		
> \$200,000 and ≤\$1.4 million	Open tender	5 written quotations	Open tender
> \$1.4 million	Open tender		

*Source: Audit analysis of HHB and K&TDHC records*

*Note: Competitive bidding is not required provided that the unit in charge certifies that the procurement is essential and the price is fair and reasonable.*



3.14 ***Non-compliance with quotation and tender requirements.*** Audit selected 90 purchase orders (Note 39) and 4 tender exercises conducted in the period from March 2019 to December 2021 and noted the following issues:

- (a) ***Quotation requirement not met.*** For 30 purchases with an amount not exceeding \$5,000, 26 (87%) were with one quotation only. Audit noted that:
  - (i) the requirement of obtaining two written quotations as far as practicable (except for urgent minor purchases) was applicable since the issuance of the second version of DHC Manual in September 2020. The same requirement was also stated in K&TDHC Operations Manual (issued in September 2021). However, 13 (43%) of the 30 purchases were made with one quotation only, and there was no documentation showing that the exemption from the requirement had been granted on the basis of urgent minor purchases; and
  - (ii) according to Operator A's Guidelines, competitive bidding was not required provided that the unit in charge certified that the procurement was essential and the price was fair and reasonable. However, in 23 (77%) of the 30 purchases, there was no documentation showing that the unit in charge had made such certification;
- (b) ***Tenders not conducted.*** According to Operator A's Guidelines and K&TDHC Operations Manual, open tenders should be conducted for purchases over \$200,000. Audit examined the list of purchases over \$200,000 but not exceeding \$1.4 million each and found that for 4 purchases, no tender had been conducted. Instead, quotations were

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**Note 39:** *The purchase orders were randomly selected from K&TDHC's registers of purchasing orders and tenders. For the 90 purchase orders, Audit selected 30 samples of purchases under each of the following categories:*

- (a) *not exceeding \$5,000;*
- (b) *exceeding \$5,000 but not exceeding \$50,000; and*
- (c) *exceeding \$50,000 but not exceeding \$200,000.*

## Administrative issues of the Kwai Tsing District Health Centre

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obtained. While both sets of guidelines have not specified the circumstances under which the tender requirement could be exempted, Operator A's Board of Directors granted approvals for exempting the tender requirement based on the merits of the purchases or urgency. With reference to DHC Manual, 5 quotations should be obtained. However, in 2 of the 4 purchases, only 1 quotation was obtained for each of the purchases;

- (c) ***Government's prior agreement not obtained on procurements over \$50,000.*** According to DHC Manual and K&TDHC Operations Manual, prior agreement should be sought from the Government on any procurement with an estimated value over \$50,000. Audit noted that:
- (i) in a financial inspection in October 2020, PHO had raised concerns that the requirement had not been complied with;
  - (ii) Operator A opined that the requirement might lengthen the procurement process unnecessarily and K&TDHC should consider discussing the requirement with PHO; and
  - (iii) under the current practice, K&TDHC informed PHO of the purchases exceeding \$50,000 after the purchases had been made, instead of seeking prior agreements. There was no evidence that PHO raised further comments; and
- (d) ***Government's prior approval not obtained on standard marking scheme framework.*** According to DHC Manual and K&TDHC Operations Manual, on adopting marking schemes for evaluation for tenders, K&TDHC should follow the standard marking scheme framework with a range of technical weighting of 50% to 70% and price weighting of 30% to 50%. Should there be any deviation from the standard framework, prior approval from the Government should be sought. Audit noted that in 2 (50%) of the 4 tender exercises examined, there was no documentation showing that prior approvals had been obtained for deviating from the standard marking scheme framework.

3.15 *Non-compliance with other procurement-related control measures.* Audit examination of the 90 purchase orders and 4 tender exercises conducted revealed the following issues relating to the implementation of procurement-related control measures set out in the procurement guidelines:

- (a) *Supervisory checks not conducted.* Supervisory checks should be conducted randomly and regularly to ensure that the quotations obtained are genuine. Audit however found that no supervisory check had been conducted; and
- (b) *Marking scheme not included in tender documents.* Pre-determined assessment criteria and marking schemes should be included in tender documents. Audit found that the marking scheme was not included in the tender document in 1 (25%) of the 4 tender exercises.

3.16 According to PHO, similar non-compliances on procurement matters were also identified in its financial inspections of K&TDHC (e.g. non-compliance with quotation requirements in the inspection of October 2020 (see para. 2.37(c))). The observations and recommendations were provided to K&TDHC, and measures taken up would be reviewed in the half-yearly audit reports submitted by K&TDHC (see para. 3.11(b)) as well as in subsequent annual PHO inspections. In view of the various instances of non-compliance with the procurement guidelines, Audit considers that HHB needs to continue to closely monitor the measures taken by K&TDHC to ensure compliance.

### ***Need to rationalise procurement guidelines***

3.17 As of June 2022, the latest position of the three sets of procurement guidelines was as follows:

- (a) *Operator A's Guidelines (see para. 3.11(a)).* The guidelines were under review by Operator A and pending approval by a committee of Operator A overseeing financial matters;
- (b) *DHC Manual (see para. 3.11(b)).* PHO updated the DHC Manual in February 2022. In this version, instead of stipulating procurement requirements for goods and services of different values (i.e. as in the second

## **Administrative issues of the Kwai Tsing District Health Centre**

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version issued in September 2020), operators were allowed to set up their own procurement procedures with reference to guidelines or best practice checklists by the Independent Commission Against Corruption or other relevant parties. PHO further updated the DHC Manual in June 2022 with no further changes on procurement matters; and

- (c) ***K&TDHC Operations Manual (see para. 3.11(c)).*** Upon the update of Operator A's Guidelines in (a), Operator A's procurement procedures would be incorporated in the K&TDHC Operations Manual for PHO's comment.

In Audit's view, HHB needs to collaborate with Operator A on K&TDHC's follow-up actions on rationalising the procurement guidelines and to ensure that they are in line with government procurement requirements set out in DHC Manual, with a view to ensuring that consistent quotation and tender requirements are applied.

## **Audit recommendations**

3.18 **Audit has *recommended* that the Secretary for Health should:**

- (a) **collaborate with Operator A on K&TDHC's follow-up actions on rationalising the procurement guidelines and to ensure that they are in line with government procurement requirements set out in DHC Manual; and**
- (b) **continue to closely monitor the measures taken by K&TDHC to ensure compliance with the procurement guidelines.**

## **Response from the Government**

3.19 The Secretary for Health agrees with the audit recommendations. He has said that:

- (a) HHB will remind and work with K&TDHC to ensure its compliance with the government procurement requirements; and
- (b) HHB has noted that K&TDHC had enhanced its internal communication to ensure compliance with its procurement guidelines.

## **Promotion efforts**

3.20 According to HHB, although promotion is not the only determinant factor of DHC membership sign up rate, in order to shift the mindset and behavioural pattern of the general public on primary healthcare services, it is important that adequate and effective promotional and publicity activities are carried out at both the territory level by PHO (see para. 4.24) and district level by DHCs. K&TDHC implemented a series of promotion strategies to enhance community awareness of its services, including carnivals, outreach activities and programmes to schools and corporates, and publicity on social media platforms and printed media (e.g. newsletters).

### ***Need to step up efforts in promoting K&TDHC***

3.21 The DHC Scheme aims at serving members at all ages (see para. 1.9(d)). Audit analysed K&TDHC members' age profile as at 31 March 2022 and compared it with the age profile of residents in the Kwai Tsing District, and the results are shown in Table 8.

**Table 8**

**Comparison of K&TDHC members' age profile and  
that of residents in the Kwai Tsing District**

<b>Age group</b>	<b>K&amp;TDHC members  (a)</b>	<b>Residents in the Kwai Tsing District (Note) (b)</b>	<b>Percentage of K&amp;TDHC members to residents in the Kwai Tsing District  (c) = (a) ÷ (b) × 100%</b>
14 or below	214	49,100	0.4%
15 to 44	1,581	173,800	0.9%
45 to 64	9,286	160,600	5.8%
65 or above	13,625	103,800	13.1%
Overall	24,706	487,200	5.1%

*Source: Audit analysis of HHB, K&TDHC and Census and Statistics Department records*

*Note: The data was extracted from the Census and Statistics Department's "Population and Household Statistics Analysed by District Council District 2021" published in April 2022. The discrepancy between the sum of number of residents in each age group and the overall total is due to rounding.*

*Remarks: Residents in the Kwai Tsing District or those working in the district may register as members of K&TDHC (see para. 1.9(d)). For the purpose of this analysis, it is assumed that all K&TDHC members are residents in the Kwai Tsing District.*

3.22 Audit noted that as at 31 March 2022, the percentage of residents in the Kwai Tsing District who joined as K&TDHC members, in particular for the younger age group (i.e. aged 44 or below), was on the low side (Note 40). There is room for recruiting more members especially among the younger population. Audit also noted that according to a survey conducted by the consultant of the monitoring and evaluation study (see para. 1.13) during the period from June 2020 to June 2021, of the 637 respondents in the Kwai Tsing District, only 35.9% were aware of K&TDHC. Some respondents commented that they did not join K&TDHC because they did not know its existence or understand its positioning or did not think they were its target users.

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**Note 40:** *According to K&TDHC, most of the target users of the chronic disease management and community rehabilitation programmes were elderly since they had a much larger demand than the younger population.*

3.23 In Audit's view, to meet the DHC Scheme's aim of serving members of all ages, HHB needs to remind K&TDHC to step up efforts to raise the public awareness of its function and to attract new members, in particular from the younger population.

***Need to continue to make better use of technology in  
promotion and provision of services***

3.24 Audit examined the promotion work of K&TDHC on social media platforms and the development of a mobile application and noted that:

- (a) K&TDHC had been making use of these platforms not only for promotion purposes, but also for providing healthcare related information to its members and the general public, in particular amid the COVID-19 epidemic;
- (b) up to 31 May 2022, it had uploaded over 350 videos on its channel on a social media platform, and some of the videos had attracted over 3,700 views each. The number of followers/subscribers of K&TDHC's fan pages and channel on social media platforms totalled some 9,400 (Note 41); and
- (c) according to the service contract, K&TDHC planned to launch a health management mobile application, which could facilitate residents to access health education information and members to manage appointments with K&TDHC (e.g. health promotion activities and patient empowerment programmes). However, there was a delay of about one year in implementing phase 1 of the plan and the mobile application was still being developed as of August 2022 (Note 42).

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**Note 41:** *There were 373, 8,129 and 931 followers/subscribers on K&TDHC's three social media platforms.*

**Note 42:** *According to K&TDHC, the development of the mobile application comprises five phases, and is then followed by a final user acceptance test, user training and a 3-month nursing period. Phase 1 of the development was scheduled for completion in September 2021 but was delayed to August 2022 (i.e. a delay of 11 months). As of August 2022, the expected launch date of the mobile application was revised from April 2022 to December 2022. The delay was because K&TDHC staff were engaged in ad-hoc tasks (e.g. vaccination programme) and that the security risk assessment and audit was in progress.*

## **Administrative issues of the Kwai Tsing District Health Centre**

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In Audit's view, HHB needs to remind K&TDHC to strengthen efforts in making better use of technology to promote and provide its services, including expediting the development of the health management mobile application in order to provide a convenient and alternative means for providing services to its members as early as practicable.

### **Audit recommendations**

**3.25      Audit has *recommended* that the Secretary for Health should remind K&TDHC to strengthen its promotion efforts, including:**

- (a)      stepping up efforts to raise the public awareness of its function and to attract new members, in particular from the younger population; and**
- (b)      making better use of technology to promote and provide its services, including expediting the development of the health management mobile application.**

### **Response from the Government**

**3.26      The Secretary for Health agrees with the audit recommendations. He has said that:**

- (a)      HHB has launched a territory-wide promotion campaign since 2022, including advertisements in train stations, TV programmes, radio programmes and social media, to raise the public awareness of DHCs as DHCs and DHCEs would be present across all 18 districts in Hong Kong within 2022; and**
- (b)      K&TDHC had launched the health management mobile application and drawn on the experience gained from the gradual development of other DHCs to make better use of technology to promote and provide its services.**



## **PART 4: PROVISION OF DISTRICT HEALTH CENTRES AND DISTRICT HEALTH CENTRE EXPRESSES**

4.1 This PART examines issues relating to the planning and development of DHCs and DHCEs, focusing on:

- (a) provision of DHCs (paras. 4.2 to 4.8);
- (b) DHCEs (paras. 4.9 to 4.23);
- (c) publicity work to promote DHC Scheme (paras. 4.24 to 4.34); and
- (d) way forward (paras. 4.35 to 4.42).

### **Provision of District Health Centres**

#### ***Need to ensure that DHCs commence operation as scheduled***

4.2 As announced in the 2019 Policy Address, the Government would set up DHCs in 7 districts and DHCEs in the remaining 11 districts within the fifth-term Government (i.e. by 30 June 2022) (see para. 1.14(b)). As at 30 June 2022, 4 DHCs and 11 DHCEs were in operation (see para. 1.16). The remaining 3 DHCs (Southern, Yuen Long and Tsuen Wan) were expected to commence operation within 2022 (see Table 9).

**Provision of District Health Centres and  
District Health Centre Expresses**

**Table 9**

**Status of 7 full-fledged DHCs  
(30 June 2022)**

Status/ District		Contract award date	Actual/expected commencement date	Gearing up period (Note 1) (month)
<b><i>Operation commenced</i></b>				
1	Kwai Tsing	March 2019	September 2019	6
2	Sham Shui Po	September 2020	June 2021	9
3	Tuen Mun	August 2021	May 2022	9
4	Wong Tai Sin	September 2020	June 2022	9 (Note 2)
<b><i>Contract awarded</i></b>				
5	Southern	March 2022	October 2022	7
6	Yuen Long			
7	Tsuen Wan	May 2022	December 2022	7

*Source: Audit analysis of HHB records*

*Note 1: According to HHB, under the DHC service contract, the operator shall normally be allowed to have a gearing up period of 8 to 10 months upon award of the contract. The actual operation date is stated in the contract and subject to the Government's final decision.*

*Note 2: According to HHB, Wong Tai Sin DHC is located in a public housing estate. Based on the completion status of the housing estate, the gearing up period started on 1 September 2021.*

4.3 Audit noted that the 4 DHCs in operation had commenced operation on schedule. For the remaining 3 DHCs, HHB had once reported to the Finance Committee of the Legislative Council in April 2022 that Southern and Yuen Long DHCs were expected to commence operation in July 2022 and Tsuen Wan DHC in November 2022. According to HHB, the commencement dates had been revised to October and December 2022 upon agreement with the operators. Audit considers that HHB needs to closely monitor the progress of the preparation work to ensure that the 3 DHCs commence operation according to the schedule.

***Need to continue efforts in setting up DHCs at permanent sites***

4.4 The Government indicated in the 2018 Policy Address that to ensure service stability, it would reserve premises for DHCs within Government properties, but would first rent suitable premises to enable early service delivery (see para. 1.14(a)). According to HHB, as of June 2022:

- (a) suitable sites had been earmarked for the long-term development of full-fledged DHCs in all 18 districts (Note 43);
- (b) for the 7 districts with full-fledged DHCs operated before or within 2022 (see para. 4.2) in rented premises, the DHCs would move to the permanent sites when they become available. The permanent sites earmarked for K&TDHC, Wong Tai Sin DHC and Sham Shui Po DHC were expected to be available by 2030. For the other 4 DHCs, the availability dates had not yet been confirmed; and
- (c) for the 11 districts with DHCEs operated in rented premises, the target completion dates of the bulk of full-fledged DHCs at the permanent sites were between 2024 to 2030 (Note 44).

While noting HHB's efforts in identifying sites for the long-term development of DHCs in all 18 districts, Audit considers that HHB needs to continue efforts in setting up DHCs at these sites (e.g. formulating a timetable for setting up all DHCs at permanent sites).

***Delays in commencement of satellite centres***

4.5 The DHC in each district comprises a core centre and several satellite centres (see para. 1.9(c)). The core centre serves as a main service site, complemented by the satellite centres in each of the sub-districts which serve as the

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**Note 43:** *According to HHB, one of the sites (i.e. the ex-Mong Kok Market site for Yau Tsim Mong DHC) would be converted into an interim DHC by the Urban Renewal Authority. In the long run, it would work closely with the Urban Renewal Authority to identify a suitable site within the district for a permanent DHC.*

**Note 44:** *For 3 of the 11 districts, the availability dates of the permanent sites for setting up full-fledged DHCs had not yet been confirmed.*

## Provision of District Health Centres and District Health Centre Expresses

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neighbourhood first contact points. According to the service contracts, operators of DHCs should set up satellite centres within a specified timeframe as agreed with the Government (Note 45). Audit noted that Operator A failed to meet the proposed timeframe for launching all the 5 satellite centres of K&TDHC. The delays ranged from 28 to 351 days, averaging 260 days.

4.6 While the commencement dates of the satellite centres met the government minimum requirement (i.e. within 12 months of the operation date of the core centre), the delay was unsatisfactory given that the commencement dates had been agreed with the Government and formed part of the service contract. In this regard, Audit noted that PHO had issued a letter to Operator A in August 2020 (see para. 2.7) to draw its attention to the unsatisfactory performance in the service provision, including the delay in setting up the satellite centres. In Audit's view, HHB needs to draw lessons from the delay in launching the satellite centres of K&TDHC and take measures to ensure the timely commencement of satellite centres of DHCs and service points of DHCEs (see para. 4.16) by operators in future.

## Audit recommendations

- 4.7 **Audit has *recommended* that the Secretary for Health should:**
- (a) **closely monitor the progress of the preparation work to ensure that the 3 DHCs commence operation according to the schedule;**
  - (b) **continue efforts in setting up DHCs at the permanent sites; and**
  - (c) **draw lessons from the delay in launching the satellite centres of K&TDHC and take measures to ensure the timely commencement of**

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**Note 45:** *In the tender exercise of a DHC service contract, potential operators are required to submit details on the delivery of services in a service proposal, which include, among others, the locations and/or commencement dates of the core centre and satellite centres. If the Government accepts the proposal for the award of the contract, it will form part of the service contract and is binding on the operator. In general, an operator should set up and fit out all satellite centres in a state of readiness to commence operation, which should not be later than 12 months of the operation date of the core centre. Operators may propose earlier commencement dates for the satellite centres.*

satellite centres of DHCs and service points of DHCEs by operators in future.

## **Response from the Government**

4.8 The Secretary for Health agrees with the audit recommendations.

## **District Health Centre Expresses**

4.9 The Government pledged in the 2019 Policy Address that for the remaining 11 districts with full-fledged DHCs yet to be set up within the fifth-term Government, smaller-scale DHCEs would be established in the interim (see paras. 1.14(b) and 1.15). In April 2021, by an invitation for proposals, HHB awarded contracts to NGOs for the operation of the 11 DHCEs at a total contract cost at \$596 million for a three-year operation period (i.e. an average of about \$18 million per annum for each district). The 11 DHCEs (in the Central and Western, Eastern, Islands, Kowloon City, Kwun Tong, North, Sai Kung, Sha Tin, Tai Po, Wan Chai and Yau Tsim Mong Districts) commenced operation in September and October 2021.

### ***Need to monitor performance of DHCEs***

4.10 In the invitation for proposals for operating DHCEs, the Government set out, for each level of prevention services, performance standards in the form of service output targets on services identified as mandatory (mandatory services). Similar to the DHC tender exercises, potential operators could propose service volume that exceeded the government requirements (see para. 2.6 and Appendix E). The 4 service output targets for mandatory services are:

- (a) ***Primary prevention.*** Number of sessions of health promotion and educational programmes;
- (b) ***Secondary prevention.*** Number of health risk factors assessments; and
- (c) ***Tertiary prevention.*** For DM and HT respectively, members joining patient empowerment programmes/health coaching services as a percentage of the number of members with DM/HT (i.e. 2 service output targets).

## Provision of District Health Centres and District Health Centre Expresses

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In addition to the mandatory services, potential operators could also propose optional services and/or other value-added services (Note 46). All 11 DHCE operators proposed service output targets in excess of the government requirements.

4.11 The 11 DHCEs commenced operation in September and October 2021. According to the service contracts, DHCE operators are required to submit quarterly service reports to PHO (Note 47). Audit requested PHO to provide statistics on DHCEs' attainment of the 4 mandatory service output targets (Note 48) for the first two quarters ended 31 March 2022, which should be available as of August 2022. In response, PHO informed Audit in August 2022 that such information for the 2 service output targets under tertiary prevention (see para. 4.10(c)) was not yet available due to limitations of the DHC IT system in compiling the relevant statistics.

4.12 For the other 2 service output targets, PHO informed Audit in September 2022 that as DHCE staff had been deployed to support HA's COVID-19 hotlines and designated clinic appointment hotline since February and March 2022 respectively (see para. 1.17(d)), it was agreed between PHO and DHCE operators to deduct the annual service output targets by one-sixth. Taking into account the adjustments, since the commencement of operations and up to 31 March 2022, of the 11 DHCEs:

- (a) 7 (64%) DHCEs attained over 100% of the primary prevention service output target; and
- (b) 6 (55%) DHCEs attained above 60% of the secondary prevention service output target.

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**Note 46:** *For example, under tertiary prevention, patient empowerment programmes for patients with DM and HT are mandatory, while those for low back pain and osteoarthritic knee pain are optional. Apart from optional services, potential operators can also propose "other value-added services", such as evidence-based services for secondary/tertiary prevention outside the predefined scope and application of advance technologies when delivering services.*

**Note 47:** *DHCEs are required to submit quarterly service reports to PHO no later than 20 days after each quarter-end date.*

**Note 48:** *As the types and service output targets of optional and other value-added services of the 11 DHCEs varied, Audit analysis focused on the attainment of the mandatory service output targets for easy comparison among DHCEs.*

## Provision of District Health Centres and District Health Centre Expresses

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According to HHB, almost all DHCE staff were deployed to provide support to HA in fighting COVID-19 during the fifth-wave of the epidemic under the Government's direction. As a result, some DHCEs services were suspended or provided on a limited scale, and hence the attainment of the targets was affected (see also para. 2.7(c)).

4.13 According to the service contracts, the Government has the right to deduct a percentage of an instalment payment if the calculated overall performance (which represents the average percentage of service output targets achieved for all mandatory and optional services) for the corresponding 12-month period is lower than or equal to 80% of the yearly agreed service output targets (Note 49). As the DHCEs only commenced operation in September/October 2021, the first assessment of the deduction of instalment payments would only be conducted in the fourth quarter of 2022. In Audit's view, HHB needs to:

- (a) closely monitor the performance of DHCEs and take timely follow-up actions as appropriate; and
- (b) address the limitations of the DHC IT system in the preparation of the relevant statistics for monitoring DHCEs' performance (see also para. 2.42).

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**Note 49:** *For the calculated overall performance, the percentage of service output achieved for each category of the service will be capped at 100% (for an over-achieved target). The percentage of payment reduction based on the calculated performance in a 12-month period is as follows:*

- (a) *if the calculated performance is over 80%, no deduction shall be made;*
- (b) *if the calculated performance is between 60% and 80% inclusive, 20% of the amount of the upcoming payment instalments (with a cap of \$0.75 million) or the amount equal to the unspent balance as at the end of the reporting period covered by the last quarterly statistical return, whichever is lower; and*
- (c) *if the calculated performance is below 60%, 40% of the amount of the upcoming payment instalments (with a cap of \$1.50 million) or the amount equal to the unspent balance as at the end of the reporting period covered by the last quarterly statistical return, whichever is lower.*

***Need to fulfill required number of  
DHCEs' healthcare service providers***

4.14 According to the service contracts of DHCEs, operators should engage and maintain a certain number of healthcare service providers (e.g. medical practitioners and allied health professionals) to provide the following services (Note 50):

- (a) ***Mandatory secondary prevention services.*** The operator of a DHCE should refer members with health risk factors for DM/HT to medical practitioners (who have joined eHRSS) practicing within the district for further assessments. The medical practitioners engaged by the operator should arrange laboratory investigations at an accredited laboratory. The operator should provide members with options for choosing medical practitioners upon referral for screening services;
- (b) ***Mandatory tertiary prevention services.*** The operator should provide members diagnosed with DM/HT with medical laboratory tests at accredited laboratories and optometry assessments by optometrists; and
- (c) ***Optional tertiary prevention services.*** For patients with DM, HT, chronic low back pain and osteoarthritic knee pain, individual healthcare professional sessions (e.g. physiotherapy and dietetics) are provided by allied health professionals.

4.15 According to the service contracts, operators should engage and maintain the number of healthcare service providers no less than that committed in the approved proposal throughout the operation period, unless otherwise agreed by the Government. Audit analysed the number of DHCEs' healthcare service providers based on the quarterly returns submitted to PHO as at 31 March 2022 and found that a significant number of DHCEs failed to engage and maintain the committed number for the mandatory categories of healthcare service providers (see Table 10). In Audit's view, HHB needs to closely monitor DHCEs' compliance with the contract requirement on engaging healthcare service providers.

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**Note 50:** *The services are charged by making reference to the co-payment arrangement of a full-fledged DHC (e.g. subsidy of \$250 for medical consultation with medical practitioners and co-payment by the member of \$150 for individual healthcare sessions (see para. 2.4(b) and (c))).*



**Table 10**

**Mandatory categories of healthcare service providers  
engaged and maintained by DHCEs  
(31 March 2022)**

<b>Category</b>	<b>Range of committed number</b>	<b>No. of DHCEs which failed to engage and maintain committed number</b>
Medical practitioners	15 to 100	7 (64%)
Accredited laboratories	1 to 10	8 (73%)
Optometrists	3 to 17	11 (100%)

*Source: Audit analysis of HHB records*

***Need to keep under review the accessibility of DHCE services***

4.16 According to the terms of the invitation for proposals, operators of DHCEs should set up in each district a core centre to serve as its primary service site. They are also encouraged to set up additional service points to improve accessibility, so as to enhance the reach of the DHCEs in the districts. The number of service points for each DHCE was agreed between the Government and the operator (Note 51).

4.17 Audit noted that the number of service points of the 11 DHCEs ranged from 1 (for 3 DHCEs) to 9 (for 2 DHCEs). To assess the accessibility of DHCE services in the districts, Audit analysed the ratio of service locations (i.e. core centre and service points) by reference to the population and land area in the respective districts (see Table 11) and found that:

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**Note 51:** *During the invitation for proposals for DHCEs, potential operators are required to submit details on the delivery of services in a service proposal, which include, among others, the locations of the core centre, the number and commencement dates of service points (if any) and service output targets. If the Government accepts the proposal for the award of the contract, it will form part of the service contract and is binding on the operator.*

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- (a) the number of service locations was not directly proportional to the population in the district. For example, while the population size of Kwun Tong (some 667,000) and Sha Tin (some 688,000) was comparable, the number of service locations for Kwun Tong DHCE (10 locations) was 5 times of that of Sha Tin DHCE (2 locations). The ratio of population per service location varied significantly, ranging from about 18,000 (Islands) to about 344,000 (Sha Tin); and
- (b) the land area served per service location varied significantly, ranging from 1.1 square kilometre (Kwun Tong) to 34.4 square kilometres (Sha Tin).

**Table 11**

**Ratio of population/land area to number of service locations of 11 DHCEs**

	Core centre (a)	Service points (b)	Service locations (c) = (a) + (b)	Population (d)	Population per location (e) = (d) ÷ (c)	Land area (f)	Land area per location (g) = (f) ÷ (c)
District	(No.)			(number of persons) (‘000)		(Square kilometre)	
Central and Western	1	1	2	233	117	12.6	6.3
Eastern	1	1	2	525	263	18.0	9.0
Sha Tin	1	1	2	688	344	68.7	34.4
Yau Tsim Mong	1	3	4	307	77	7.0	1.8
North	1	3	4	305	76	136.5	34.1
Kowloon City	1	4	5	404	81	10.0	2.0
Wan Chai	1	5	6	165	28	10.6	1.8
Sai Kung	1	6	7	486	69	129.7	18.5
Tai Po	1	7	8	313	39	136.1	17.0
Kwun Tong	1	9	10	667	67	11.3	1.1
Islands	1	9	10	183	18	181.5	18.2

Source: Audit analysis of HHB and Census and Statistics Department records

Remarks: The population and land area are based on the Census and Statistics Department’s “Population and Household Statistics Analysed by District Council District 2021” (published in April 2022) and “Land area, mid-year population and population density by District Council district (2021)” (published in March 2022) respectively.

4.18 While it is not a mandatory requirement for operators of DHCEs to set up additional service points, to maintain the momentum for promoting primary healthcare, there are merits for HHB to keep under review the accessibility of DHCE services, taking into account the service demand, user feedback and the number of service locations of DHCEs (in particular, the districts where the population and land area per service location are on the high side (e.g. Sha Tin)), and take follow-up actions as appropriate (e.g. consider setting a minimum number of service points in future service contracts).

***Need to keep under review the governance structure of DHCEs***

4.19 Under the current governance structure of the DHC Scheme, the Steering Committee oversees high level issues concerning DHCs and DHCEs. For DHCs, the cluster-level Governing Committees and DHC-specific Executive Committees have also been established to provide guidance and oversight to DHC operators (see para. 1.8 and Appendix C). Individual DHCs are required to report on their progresses and service performance regularly to their respective committees. On the other hand, the structure with multiple levels of oversight and the reporting requirements adopted by DHCs are not in place for DHCEs.

4.20 According to HHB, PHO is responsible for overseeing DHCEs' operation and performance, and would regularly report DHCEs services to the Steering Committee (Note 52). Bi-monthly meetings are conducted to facilitate experience sharing among the DHCE operators. In Audit's view, given that DHCEs have been in operation since September/October 2021 and they are one of the key service providers of district-based primary healthcare until the bulk of full-fledged DHCs are set up (i.e. in 2024 to 2030 — see para. 4.4(c)), there are merits for HHB to keep under review the governance structure for overseeing DHCEs and take follow-up actions as appropriate.

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**Note 52:** *For example, in May 2022, HHB reported to the Steering Committee the aggregated overall service level of DHCs/DHCEs in terms of number of members and total attendance. As at 31 December 2021, over 33,000 members had joined one of the DHCs or DHCEs, with a total service attendance of some 177,000 (comprising around 100,000 in primary prevention, 47,000 in secondary prevention and 30,000 in tertiary prevention).*

***Need to issue service manual to operators of DHCEs***

4.21 To ensure service quality and consistency in service delivery across operators of DHCs, PHO has issued DHC Manual (see para. 2.5) to DHC operators. For the 11 DHCEs, while PHO has incorporated guidelines on some procedures in the service contracts signed with the operators, such guidelines do not cover detailed operational procedures. For example, operators shall maintain proper books, accounts and all relevant records and information related to DHCs and DHCEs. However, while detailed guidelines on maintaining proper books and accounts have been stipulated in DHC Manual (e.g. a detailed list of books of account and accounting records to be kept), these guidelines have not been set out for DHCEs. To ensure service quality and consistency in service delivery across the 11 DHCEs as well as facilitate monitoring, HHB should consider the need to issue a service manual for DHCEs, making reference to DHC Manual.

**Audit recommendations**

4.22 **Audit has *recommended* that the Secretary for Health should:**

- (a) **closely monitor the performance of DHCEs and take timely follow-up actions as appropriate;**
- (b) **closely monitor DHCEs' compliance with the contract requirement on engaging healthcare service providers;**
- (c) **keep under review the accessibility of DHCE services, taking into account the service demand, user feedback and the number of service locations of DHCEs, and take follow-up actions as appropriate;**
- (d) **keep under review the governance structure for overseeing DHCEs and take follow-up actions as appropriate; and**
- (e) **consider the need to issue a service manual for DHCEs, making reference to DHC Manual.**

## Response from the Government

4.23 The Secretary for Health agrees with the audit recommendations.

### Publicity work to promote District Health Centre Scheme

4.24 Since the opening of K&TDHC in 2019, PHO has been promoting the DHC Scheme to the general public. With the commencement of more DHCs and DHCEs, PHO kick-started a territory-wide publicity campaign in November 2021 to enhance promotion and publicity of the DHC Scheme (e.g. advertising through multiple marketing channels including advertisements in train stations and on television and radio programmes) to raise the awareness of DHCs. In March 2022, PHO engaged an agency to provide services for the promotion and publicity campaign. Also, a grand ceremony was held in June 2022 for marking a new milestone in the development of DHCs and primary healthcare.

### *Need to improve dissemination of service information on websites*

4.25 ***PHO one-stop website.*** To promote the DHC Scheme, PHO has set up a one-stop website to provide information of the DHC Scheme (e.g. scope of primary healthcare services provided by DHCs, and eligibility for DHC membership or NSPs). The website also contains information on each of the DHCs and DHCEs. Audit reviewed the website and found that, as at 31 May 2022:

- (a) it contained basic information on each DHC and DHCE, including the contact information and opening hours of DHCs/DHCEs' core centres. However, information about DHCs' satellite centres and DHCEs' service points was not provided; and
- (b) it contained links to the dedicated websites of individual DHCs/DHCEs set up by the operators that provide centre-specific information. Audit noted that the link to the dedicated website of Tuen Mun DHC was not yet available. Audit further checked the one-stop website on 31 July 2022

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(i.e. two months after the commencement of Tuen Mun DHC on 31 May 2022) and the situation remained the same (Note 53).

In Audit's view, HHB needs to take measures to enhance the dissemination of information about the DHC Scheme on PHO's one-stop website, including providing information about DHCs' satellite centres and DHCEs' service points and the links to dedicated websites of all DHCs/DHCEs.

4.26 ***DHCs' dedicated websites.*** As at 31 May 2022, 3 DHCs were in operation, namely, K&TDHC, Sham Shui Po DHC and Tuen Mun DHC. Audit noted that while the information on websites of K&TDHC and Sham Shui Po DHC was more comprehensive (Note 54), some key information (e.g. service scope and service charges) was not yet available on Tuen Mun DHC website as at 31 July 2022 (Note 55).

4.27 ***DHCEs' dedicated websites.*** As at 31 May 2022, all 11 DHCEs had set up dedicated websites. There are no requirements in the service contracts on the type of information to be provided on the websites. Audit reviewed the 11 dedicated websites as at 31 May 2022 (see Appendix F) and found that the amount of information available varied and some of the information provided was inaccurate. For example:

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**Note 53:** *According to PHO, the dedicated website of Tuen Mun DHC was first launched in June 2022 with the Traditional Chinese version. The Simplified Chinese and English versions were added in July 2022. However, problems were found on the language setting when trying to create website links. In August 2022, the operator fixed the problems and PHO added the links of the three versions of the dedicated website of Tuen Mun DHC to PHO's one-stop website.*

**Note 54:** *Information shown on the two DHCs' websites include: general information (e.g. address and opening hours of service centres), services and activities (e.g. service scope, service charges and list of NSPs), members registration and NSPs enrolment (e.g. eligibility and procedures), and other useful information (e.g. resource hub/community resources). A more detailed list of information available on DHC websites is at Appendix F as a benchmark for DHCE websites.*

**Note 55:** *As at 31 July 2022, the addresses and opening hours of service centres, list of NSPs, activities calendar and membership eligibility and registration procedures were shown on Tuen Mun DHC website.*

- (a) information on addresses and opening hours of service points (see para. 4.16) was available on 8 (73%) and 7 (64%) websites respectively; and
- (b) the list of healthcare service providers of DHCEs was available on 8 (73%) websites. However, on 4 (50%) of these 8 websites, there were discrepancies between the number of healthcare service providers in the English and Chinese versions of the websites.

4.28 In Audit's view, HHB needs to encourage operators of DHCs/DHCEs to provide more information on the dedicated websites (e.g. addresses and opening hours of service points) to further promote the DHC Scheme and facilitate the public to use DHC/DHCE services.

***Need to disclose information about barrier-free facilities on websites***

4.29 DHCs and DHCEs provide primary healthcare services for the general public as a whole, including those with special needs (elderly and persons with disabilities). To enhance the accessibility of DHC/DHCE services for clients with special needs, in the tender and invitation for proposals exercises, HHB has required potential operators to indicate in their proposals information on barrier-free facilities (that would be available in the proposed core centres and/or satellite centres/service points), that would become part of the service contracts after the Government accepted the proposals. The barrier-free facilities that were most commonly proposed in the DHCs/DHCEs proposals included accessible entrances, accessible lifts, accessible toilets and tactile guide paths.

4.30 Audit noted that as at 31 May 2022, none of the DHCs and DHCEs disclosed information about the barrier-free facilities provided at the service locations on their dedicated websites. In Audit's view, as a good practice, HHB needs to encourage the operators to disclose information about barrier-free facilities on the dedicated websites.

***Need to improve publicity efforts on social media platforms***

4.31 Operators of DHCs/DHCEs are required to carry out promotion and publicity programmes in the districts according to the service contracts. Use of social media platforms is a common means proposed by operators to promote DHCs/DHCEs. Audit examined the three social media platforms of the DHCs (Note 56) and DHCEs as at 31 May 2022, and noted that some operators of DHCEs had not launched fan pages/channels on social media platforms as proposed some 8 months after the opening of DHCEs, and that the number of followers/subscribers was on the low side (see Table 12).

**Table 12**

**Social media fan pages/channels launched by DHCE operators  
(31 May 2022)**

<b>Social media platform</b>	<b>No. of DHCE operators proposed to launch fan pages/channels</b>	<b>Actual no. of DHCE operators launched fan pages/channels</b>	<b>No. of followers/subscribers</b>
A	11	11 (100%)	179 to 917
B	8	4 (50%)	33 to 133
C	10	6 (60%)	1 to 143

*Source: Audit analysis of HHB and DHCEs records*

4.32 As the DHC Scheme is a new service model in promoting primary healthcare, it is important to raise the public awareness of DHC/DHCE services as early as possible, Audit considers that HHB needs to take measures to ensure that operators of DHCEs implement the publicity programmes as proposed in the service contracts, including making effective use of social media platforms.

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**Note 56:** *Use of social media platforms for promotion of K&TDHC is covered in paragraph 3.24. For Sham Shui Po DHC, the number of followers/subscribers to the three social media platforms ranged from 16 to 2,185 (averaging 781) as at 31 May 2022. Tuen Mun DHC was excluded from the examination as it had only commenced operation on 31 May 2022.*



## **Audit recommendations**

- 4.33      **Audit has *recommended* that the Secretary for Health should:**
- (a)      **take measures to enhance the dissemination of information about the DHC Scheme on websites, including:**
    - (i)      **providing information about DHCs' satellite centres and DHCEs' service points and the links to dedicated websites of all DHCs/DHCEs on PHO's one-stop website; and**
    - (ii)     **encouraging operators of DHCs/DHCEs to provide more information on the dedicated websites;**
  - (b)      **encourage operators of DHCs/DHCEs to disclose information about barrier-free facilities on the dedicated websites; and**
  - (c)      **take measures to ensure that operators of DHCEs implement the publicity programmes as proposed in the service contracts, including making effective use of social media platforms.**

## **Response from the Government**

4.34      The Secretary for Health agrees with the audit recommendations. He has said that:

- (a)      information about DHCs' satellite centres and the links to dedicated websites have been published on PHO's one-stop website;
- (b)      HHB will encourage DHC/DHCE operators to provide more information on the dedicated websites (e.g. information about barrier-free facilities); and
- (c)      HHB will continue to closely monitor DHCE services to ensure their compliance with the service contracts.

## **Way forward**

4.35 As announced in the 2021 Policy Address, HHB, with the advice from the Steering Committee, has proceeded with a comprehensive review on the planning of primary healthcare services and governance framework to formulate a blueprint for the sustainable development of primary healthcare services in Hong Kong with a view to creating a sustainable healthcare system, improving the overall health status of the population and reducing avoidable demand for secondary and tertiary healthcare. In the 2022 Policy Address, the Government announced that it would publish the Primary Healthcare Blueprint within 2022.

### ***Need to enhance collaboration with other primary healthcare service providers***

4.36 According to a paper on the blueprint submitted to the Steering Committee, the Government recognises that the current primary healthcare system is fragmented with a lack of overall strategic planning and coordination on service development and integration, which has resulted in inefficiencies in resource use and misalignment of incentives. It is proposed, among others, to gradually transform PHO into an overarching governing body (i.e. the Primary Healthcare Authority) to oversee primary healthcare services, review and realign the roles of different key service providers (e.g. DH and HA), as well as to enhance cross-sectoral and inter-organisational coordination, thereby ensuring effective and efficient utilisation of resources. As the service model and scale of DHCs continue to grow and solidify, and given a considerable extent of service duplication, certain DH's primary healthcare functions (e.g. elderly health services and cancer prevention) will be gradually integrated into DHCs.

4.37 In this connection, according to HHB, it has been exploring ways to enhance the collaboration among DHCs and other service providers (e.g. DH and HA) in the delivery of primary healthcare services, or better position HA and DHCs' similar functions to target at difference clientele. For instance, the primary prevention activities of DH's Elderly Health Centres (e.g. fall prevention or nutrition classes) are planned to be gradually shifted to DHCs. In addition, in view of the challenge of

unmet demand for the services provided in the Elderly Health Centres (Note 57), a service interface mechanism has been set up with DHCs. Under the mechanism, elders who are on the waiting list and wish to enrol as new members of the Elderly Health Centres are offered an alternative option of DHCs (Note 58).

4.38 Audit noted that the service interface arrangement with DH was only applicable to DHCs but not for DHCEs. In Audit's view, before the realignment of services among the key public primary healthcare service providers pending the establishment of the Primary Healthcare Authority, HHB needs to continue to explore ways to enhance the collaboration among DHCs and other primary healthcare service providers (e.g. DH and HA) in the delivery of primary healthcare services (e.g. extending the service interface arrangement to DHCEs).

***Need to take into account audit findings in  
launching full-fledged DHCs***

4.39 According to the Government, the setting up of DHCs is a crucial step in changing the healthcare system in Hong Kong. With the continuous development of DHCs across the territory, the primary healthcare service delivery model will gradually evolve into a district-based community health system with a view to triggering a paradigm shift of the present healthcare system and people's mindset from treatment-oriented to prevention-focused, thereby achieving the objectives of enhancing overall public health and reducing unwarranted use of hospital resources. Audit noted that the targets set for the DHC/DHCE operators were mainly on service output (see paras. 2.6 and 4.10). As DHCs will become a key component of the primary healthcare system, HHB needs to consider setting outcome targets and/or indicators for measuring the effectiveness of the DHC Scheme in the longer term. In Audit's view, as the service model and scale of DHCs continue to grow and evolve, HHB also needs to take into account the audit observations and recommendations in this Audit Report in launching full-fledged DHCs and refining the DHC Scheme.

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**Note 57:** *During the COVID-19 epidemic, some of the services of the Elderly Health Centres were suspended. According to the information published by DH as of September 2022, the estimated waiting time of enrolment for the 18 Elderly Health Centres ranged from 10 to 43 months for the applications submitted as of November 2021.*

**Note 58:** *As health risk assessments provided by DHCs do not cover all aspects of the Elderly Health Centre's health assessment (e.g. visual, cognitive and mood), elders can continue to register on the Elderly Health Centres waiting list while receiving DHC services.*

## **Audit recommendations**

- 4.40      **Audit has *recommended* that the Secretary for Health should:**
- (a)      **continue to explore ways to enhance the collaboration among DHCs and other primary healthcare service providers (e.g. DH and HA) in the delivery of primary healthcare services (e.g. extending the service interface arrangement to DHCEs);**
  - (b)      **consider setting outcome targets and/or indicators for measuring the effectiveness of the DHC Scheme in the longer term; and**
  - (c)      **take into account the audit observations and recommendations in this Audit Report in launching full-fledged DHCs and refining the DHC Scheme.**

## **Response from the Government**

4.41      The Secretary for Health agrees with the audit recommendations. He has said that HHB will take into account the audit observations and recommendations in the Audit Report together with the Primary Healthcare Blueprint which will be published within 2022 in refining the DHC Scheme. In particular, the Blueprint will review the primary healthcare service delivery and governance structure within the district-based primary healthcare system, including the relevant positioning of and enhancing of collaboration among DHCs and other primary healthcare providers (including DH, HA, the private medical sector, NGOs, etc.) across the public and private sectors.

4.42      The Director of Health has said that DH's Elderly Health Centres stand ready to extend the service interface arrangements to DHCEs, and would welcome initiatives from HHB to enhance collaboration with DHCs and DHCEs.

### Major primary healthcare development milestones

Year	Milestone
2009	<ul style="list-style-type: none"> <li>• Elderly Health Care Voucher Scheme launched (Note 1)</li> </ul>
2010	<ul style="list-style-type: none"> <li>• Primary Care Office set up under DH (Note 2)</li> <li>• Two Reference Frameworks for Diabetes Care and Hypertension Care for Adults in Primary Care Settings published (Note 3)</li> </ul>
2011	<ul style="list-style-type: none"> <li>• Primary Care Directory launched (Note 4)</li> </ul>
2012	<ul style="list-style-type: none"> <li>• Two Reference Frameworks for Preventive Care for Older Adults and Children in Primary Care Settings published (Note 3)</li> </ul>
2017	<ul style="list-style-type: none"> <li>• Chief Executive announced the setting up of a District Health Centre (see para. 1.5)</li> <li>• Steering Committee on Primary Healthcare Development established (see para. 1.6)</li> </ul>
2019	<ul style="list-style-type: none"> <li>• Primary Healthcare Office established under the Health Bureau (see para. 1.7)</li> <li>• Former Primary Care Office integrated with the Primary Healthcare Office</li> </ul>

Source: Health Bureau records

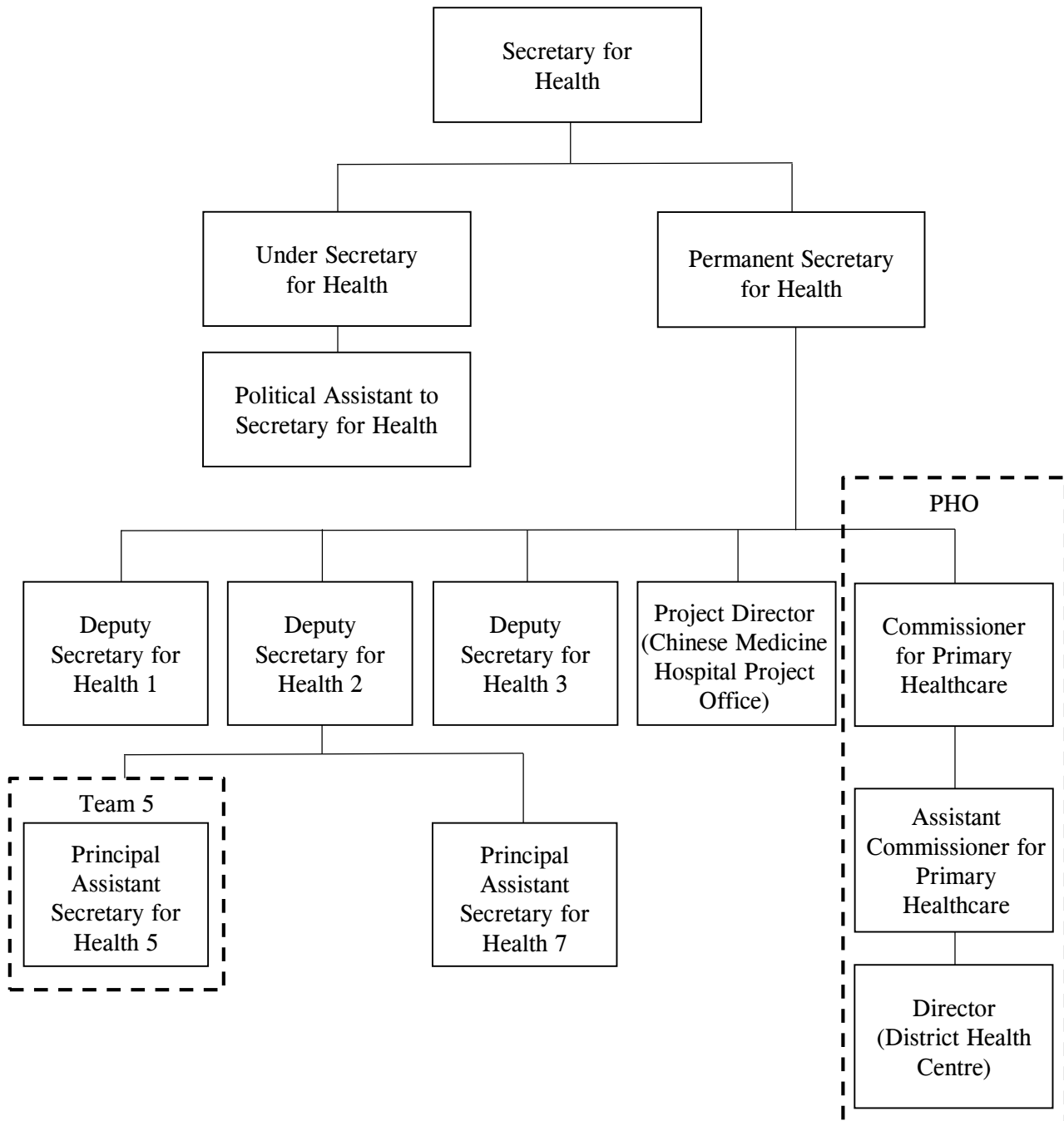
*Note 1: The Scheme provides subsidies for eligible elders to choose private primary healthcare services in their local communities that best suit their health needs. Vouchers can be spent on healthcare services provided by medical practitioners, Chinese medicine practitioners, dentists, nurses, physiotherapists, occupational therapists, radiographers, medical laboratory technologists, chiropractors and optometrists with Part I registration under the Supplementary Medical Professions Ordinance (Cap. 359).*

*Note 2: The Primary Care Office was set up to support and coordinate the development of primary care, with particular focus on coordinating public and private healthcare providers in the implementation of population-wide policies and strategies to enhance primary care.*

*Note 3: Reference frameworks provide common reference to healthcare professionals for the provision of continuing, comprehensive and evidence-based care in the community, empower patients and their carers, and raise public awareness on management of health.*

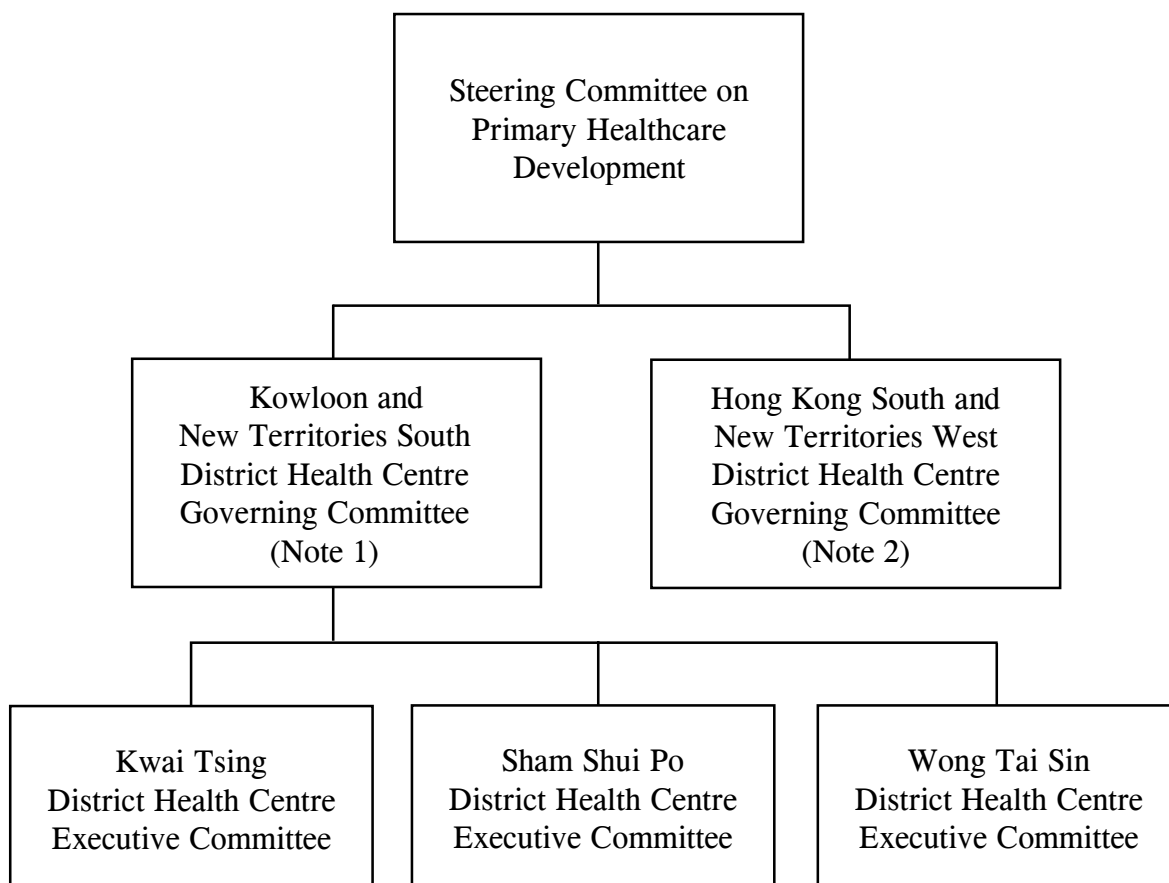
*Note 4: The Primary Care Directory is a web-based database providing practice information and professional qualification of primary care providers including doctors, dentists and Chinese medicine practitioners.*

**Health Bureau:  
Organisation chart (extract)  
(1 July 2022)**



*Source: HHB records*

**Governance structure of  
District Health Centre Scheme  
(30 June 2022)**



*Source: HHB records*

*Note 1: The Kowloon and New Territories South District Health Centre Governing Committee is also tasked to oversee the operation of Tsuen Wan DHC, which is expected to commence operation in December 2022.*

*Note 2: The Hong Kong South and New Territories West District Health Centre Governing Committee oversees the operation of DHCs in the Tuen Mun, Yuen Long and Southern Districts.*

**Appendix D**  
(para. 2.4(c) and Table 5  
in para. 2.25 refer)

**Subsidised individual healthcare service sessions  
(31 March 2022)**

Programme	Type of sessions					Maximum no. of sessions
	Dietetics	Physiotherapy	Occupational therapy	Chinese medicine services (Note 1)	Others	
<i>Chronic disease management programme (Note 2)</i>						
DM	✓	✓	✓		Optometry Podiatry	First year: 6 Subsequent: 4
HT	✓	✓	✓		Optometry Podiatry	4 per year
Low back pain	✓	✓	✓	✓		8
Osteoarthritic knee pain	✓	✓	✓	✓		12
<i>Community rehabilitation programme (Note 3)</i>						
Stroke	✓	✓	✓	✓	Speech therapy	11
Hip fracture	✓	✓	✓			8
Post-acute myocardial infarction	✓	✓	✓			8

Source: HHB and K&TDHC records

Note 1: Chinese medicine services include acupuncture and acupressure treatments.

Note 2: For the chronic disease management programmes:

- (a) if a member is diagnosed with DM and HT at the same time, the higher of the maximum number of sessions of the two programmes applies (i.e. 6 sessions in the first year and 4 sessions in subsequent years);
- (b) each member can enrol in the Low Back Pain Management Programme once only; and
- (c) each member can enrol in the Osteoarthritic Knee Pain Management programme once for each knee.

Note 3: For the community rehabilitation programmes, the maximum number of subsidised sessions applies to each referral from HA or NMPs.



## Mandatory service output targets of District Health Centre Expresses

District	Service output targets for each 12-month period			
	Primary prevention	Secondary prevention	Tertiary prevention	
	No. of sessions (including no. of sessions with more than 10 attendees per session)	No. of assessments	Percentage of members joining patient empowerment programmes or health coaching services to no. of members with	
			DM	HT
Government requirement				
All DHCEs	150 (80)	2,200	30%	30%
Annual target proposed and accepted				
Central and Western	156 (80)	2,200	30%	30%
Eastern	156 (80)	2,200	30%	30%
Islands	165 (88)	2,420	30%	30%
Kowloon City	180 (80)	2,600	35%	35%
Kwun Tong (Note)	156 (80)	2,400	30%	30%
North	180 (90)	2,300	31%	31%
Sai Kung	1,000 (825)	2,600	45%	45%
Sha Tin	156 (80)	2,200	30%	30%
Tai Po (Note)	156 (80)	2,300	30%	30%
Wan Chai	530 (200)	4,000	35%	35%
Yau Tsim Mong	180 (80)	2,600	35%	35%

*Source: Audit analysis of HHB records*

*Note: Separate targets are set for each of the three service years, the targets shown in this table represents those for the first service year.*

**Availability of information on dedicated websites of  
11 District Health Centre Expresses  
(31 May 2022)**

<b>Information</b>	<b>No. of websites</b>
<b><i>General information</i></b>	
Core centre: address and opening hours	11 (100%)
Service points: address	8 (73%)
Service points: opening hours	7 (64%)
<b><i>Services and activities</i></b>	
Service scope and service charges	11 (100%)
List of healthcare service providers	8 (73%)
Activities calendar	10 (91%)
<b><i>Members registration</i></b>	
Member eligibility and registration procedure	10 (91%)
Client journey	8 (73%)
<b><i>Healthcare service providers enrolment</i></b>	
Categories and operating districts eligible to become DHCEs' healthcare service providers	9 (82%)
Link to HHB's website on enrolment details	6 (55%)
<b><i>Other useful information</i></b>	
Latest updates	10 (91%)
Special service arrangements under the COVID-19 epidemic	10 (91%)
Resource hub/community resources	10 (91%)
Frequently asked questions	7 (64%)

Source: Audit analysis of DHCEs records

**Acronyms and abbreviations**

Audit	Audit Commission
DH	Department of Health
DHC	District Health Centre
DHCE	District Health Centre Express
DM	Diabetes mellitus
eHRSS	Electronic Health Record Sharing System
FHB	Food and Health Bureau
HA	Hospital Authority
HHB	Health Bureau
HT	Hypertension
IT	Information technology
K&TDHC	Kwai Tsing District Health Centre
NGO	Non-governmental organisation
NMP	Network medical practitioner
NSP	Network service provider
PHO	Primary Healthcare Office