

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.

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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).

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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).

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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:

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- (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));**

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- (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));**

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- (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.