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Transforming Chinese Medicine Through System Development and Integration

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Prologue

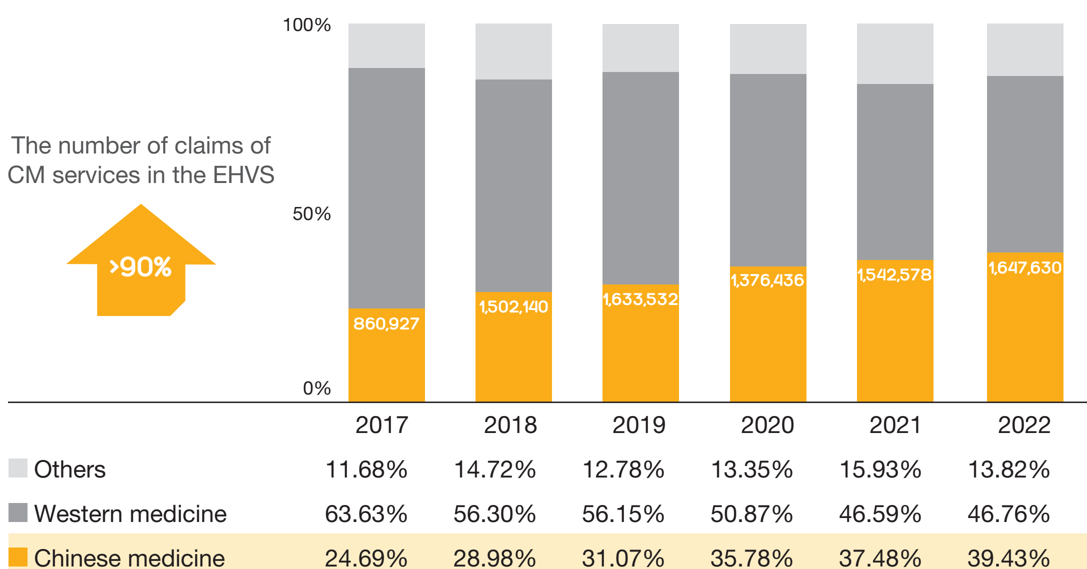
Chinese Medicine Development: An Overview

In the past twenty years, there has been significant progress in the professional development of Chinese medicine (CM). This has increased confidence in its effectiveness and led to a recognition that both CM and western medicine offer distinct advantages. In response to these developments, the Government has actively fostered the growth of CM to address the diverse healthcare needs of the public.

CM, with its emphasis on the concepts of “strengthening one’s innate health and cultivating vitality（固本培元）”, “syndrome differentiation and treatment（辨證論治）”, “holistic approach（整體觀念）”, and “moderate treatment and conditioning（溫和調理）”, offers unique advantages that complement the treatment-based healthcare system in Hong Kong (Wong et al., 2012; 國立中國醫藥研究所, 2002a, 2002b; 孫其新, 2008; 馬萬里, 劉昭純, 2019). This not only aligns with the Government's vision outlined in the *Primary Healthcare Blueprint* earlier, but also contributes to improving the overall health of the public while reducing long-term healthcare and financial burdens on the community.

The elderly have increasingly valued the preventive and holistic benefits of CM, a trend that is clearly reflected in the number of claims and share of CM services in the Elderly Health Care Voucher Scheme (EHVS). The number of claims for CM services rose from 860,927 in 2017 to 1,647,630 in 2022, representing a remarkable growth of 91.38%. At the same time, its share increased significantly from 24.69% in 2017 to 39.43% in 2022. These changes indicate a growing preference and demand for CM among the elderly population (Department of Health, 2019, 2024; Legislative Council, 2023).

Figure 1 Trends in the Use of CM Services in EHVS



	2017	2018	2019	2020	2021	2022
Others	11.68%	14.72%	12.78%	13.35%	15.93%	13.82%
Western medicine	63.63%	56.30%	56.15%	50.87%	46.59%	46.76%
Chinese medicine	24.69%	28.98%	31.07%	35.78%	37.48%	39.43%

Source: Department of Health, 2019, 2024; Legislative Council, 2023

World Health Organization and the Role of Traditional Medicine

The World Health Organization (WHO) has long been attentive to the role and function of traditional medicine in primary healthcare development. The *Alma-Ata Declaration*, published in 1978, emphasised the role of traditional practitioners in providing primary healthcare and referral services to improve local health conditions (World Health Organization, 1978). In addition, in 2002, 2013, 2018, and 2022, WHO issued guidances on traditional and complementary medicine, including its integration into primary care and referral systems. The guidelines further clarified the significant roles that traditional medicine can play in primary care practice, including the prevention and management of chronic diseases, alleviation of symptoms or disease control, and enhancing healthcare accessibility to improve public health (World Health Organization, 2002, 2009, 2013, 2017, 2018, 2019).

Primary Healthcare Blueprint

Primary Healthcare Blueprint acknowledges that "CM plays an important role in the area of primary healthcare to safeguard public health and well-being in concerted efforts with the other healthcare professions". (Health Bureau, 2022e) This is achieved through various means such as including CM in the reference framework, strategic purchasing, and the formulation of primary healthcare training programmes for Chinese medicine practitioners (CMPs). It shows that developing CM can meet individuals' healthcare needs and align with the international practice, as well as Hong Kong policy directions.

CM practitioners, like family doctors, can provide primary care services as well as continuity of care.

Patient focus group interviewee

Research Objective, Framework and Methodology

While promoting the advancement of CM, it is crucial for the Government to address the multifaceted aspects of CM practices including both software and hardware, and enhance the coordination between Chinese and Western medicine within the broader healthcare system. This holistic approach is essential not only for meeting the growing healthcare demands but also for improving patient outcomes in Hong Kong by utilising the strengths of both traditional and modern systems. In light of this, our study explores how can CM be promoted systematically and be better integrated into the healthcare system.

Drawing reference from the WHO framework, to strengthen the healthcare system, we should focus on the following six key components: (1) leadership and governance, (2) service delivery, (3) health workforce, (4) health system financing, (5) health information systems, and (6) medical technology and clinical research (World Health Organization, 2007). This report also adopts the WHO framework to conduct a comprehensive assessment of the role and function of CM services within Hong Kong's healthcare system, particularly in primary healthcare services.

To achieve this goal, this study incorporates the following two qualitative research: conducting focus group and in-depth interviews with patient groups and key stakeholders from both CM and other healthcare sectors.

Figure 2 Research Framework

Source: World Health Organization, 2007

1 Strengthening CM Governance and Enhancing Its Role

1.1 Varying Focus of CM Organisations

The CM industry in Hong Kong currently has a decentralised organisational structure. According to the Chief Executive Election Ordinance (Cap. 569), there are 56 groups representing the CM sector (HKSARG, 2024c). Each entity within the industry has a certain degree of influence, but there is a lack of close collaboration and coordination among them. The different perspectives and goals of these institutions can make it challenging to bring together the efforts of various groups to jointly promote the unified development of the industry. Additionally, the absence of representative institutions makes it difficult for the Government to obtain comprehensive input and achieve consensus during the policymaking process. This situation can lead to biases or omissions in policy formulation, therefore failing to fully meet the actual needs and development directions of the industry.

1.2 CMDC Facing Difficulties in Promoting Professional Autonomy

The Chinese Medicine Development Committee (CMDC) faces certain constraints in promoting professional development within the CM industry. Although its terms of reference includes reviewing and evaluating the need on talent cultivation, service quality, scientific innovation, and industry development, as well as providing advisory and supervisory functions for priority projects, practical challenges are still evident (Health Bureau, 2023).

Critics have observed that the limited frequency of committee meetings hinders timely responsiveness to industry needs and challenges. Additionally, the absence of specific and comprehensive clinical practice guidelines in CM limits the committee's ability to provide the Government with targeted and actionable recommendations, thereby limiting the professional autonomy of the CM industry.

1.3 Recommendation 1: Establish a CM Clinical Expert Panel

- The Government should establish a CM Clinical Expert Panel comprised of authoritative scholars and practitioners within the CM sector. This panel could be organised under the structure of Chinese Medicine Hospital (CMH), with the responsibility of regularly developing and updating clinical guidelines. Additionally, the CM Clinical Expert Panel should provide professional clinical guidelines to the Government, Expert Panel on Reference Frameworks, CMH, and CMPs.
- The CM Clinical Expert Panel should develop specific clinical guidelines for disease areas that CM has advantages, based on evidence-based medicine and "syndrome differentiation and treatment" methodology, with regular updates to reflect the latest research findings.
- The Government needs to strengthen communication with CM Clinical Expert Panel to ensure that industry opinions are adequately considered in policymaking.

If a team of experts can be established to provide clinical expertise, it will assist the Government in formulating relevant clinical guidelines for various programmes involving CMPs.

Staff of Health Bureau Chinese Medicine Unit

1.4 Recommendation 2: Empower the CMDC

- The Committee should increase the frequency of its meetings, optimise meeting agenda, and strengthen communication and collaboration among members.
- The Committee should work closely with the Government and the CM Clinical Expert Panel, actively participating in the formulation and revision of related policies.
- The Committee should commission professional institutions or universities to conduct in-depth research to clearly define the development direction of the CM industry and strive for the Government support to open up more development opportunities.

2 Comprehensive Review of Service Delivery Model

2.1 Updates Required on CMCTR Operation Models

Over the last 20 years, there has been a steady increase in the use of services at Chinese Medicine Clinics cum Training and Research Centres (CMCTRs), along with a wider range of services being offered (HKSARG, 2022c). However, during this time, the Government has not systematically reviewed the consultation services, training, and research aspects of CMCTRs. This has raised concerns about whether the original arrangements of CMCTRs can continue meeting the long-term needs of the public for CM services.

THE CONSULTATION SERVICE ASPECT

a Challenges in Prompt Service Access

i / Insufficient Manpower and Treatment Capacity

Currently, CMCTRs offer a diverse range of CM services. However, the existing facilities and human resources are insufficient to fully meet the public's demand for these services. The annual Government-subsidised outpatient quotas have increased from 620,000 to 800,000, placing added strain on the existing facilities (HKSARG, 2022c). Additionally, the shortage of manpower hampers efforts to improve service quality.

Furthermore, the feedback from service users reveals that even after successful scheduling of CM services, excessively long waiting times for treatment are common. This indicates potential inadequacies in the treatment equipment and facilities of CMCTRs, which hinder their ability to effectively manage the current service volume and deliver comprehensive CM treatment.

ii / Challenges in Subsidised Quota Allocation and Transparency

Multiple service users emphasised in the focus group that there are insufficient subsidised quotas. They mentioned that it takes several days to successfully make an appointment, which has reduced their satisfaction with CMCTRs' services.

Additionally, it was pointed out that there is a lack of clear criteria on the distribution of subsidised quotas for CMCTRs among different districts. Since CMCTRs' subsidised services are provided by the on-duty CMP while service users are not allowed to specify CMP for subsidised service, the popularity of non-subsidised services in some CMCTRs is relatively low, making it difficult to meet the Government's requirements on subsidised services in the service agreement. However, other CMCTRs are facing the problem of insufficient subsidised quotas. These reflect the lack of flexibility in the allocation of subsidised quotas which results in a resource mismatch, indicating that the resource allocation still needs to be improved.

THE TRAINING ASPECT

b Insufficient Emphasis on CM Teaching

Currently, CMCTRs primarily focus on addressing service users' needs and maintaining day-to-day operations. However, junior CMPs and students need enough practical opportunities and guidance to develop solid treatment skills and knowledge. The prevailing model of prioritising consultation services over personnel training prevents experienced CMPs from providing adequate guidance and training to junior CMPs and students, hindering learning outcomes and professional development.

c Deficiencies in Promotion Ladder

The terms of employment and compensation for CMPs in CMCTRs are determined by the operating institutions of each CMCTR. This has resulted in a non-uniform compensation system for CMPs. Additionally, the remuneration of CMPs is not adjusted based on their seniority and performance, contributing to staff turnover and creating gaps in professional expertise.

**Currently, universities often send students to clinics for shadowing, but rarely arrange for clinical mentoring.
HA should include in the service agreements for universities to send CM professors for regular clinical mentoring.**

Staff of CMCTR

THE RESEARCH ASPECT

d Need for Greater Investment in Research

Universities are tasked with fostering research development at CMCTRs under the tripartite collaboration model. However, as universities establish their own clinics for teaching and research, their contribution to the development of CMCTRs has reduced. Given the shortage of CMPs at CMCTRs, self-financing NGOs prioritise meeting consultation service demands, including the Government's requirements for subsidised quotas and providing adequate non-subsidised services to cover operational costs. This lack of incentives hinders the promotion of research development.

2.2 Limited Involvement of CM in Primary Healthcare

To support the ongoing and evidence-based primary care in the community, the Government has set up the Expert Panel on Reference Frameworks, responsible for creating Reference Frameworks.

The Government, outlined in the *Primary Healthcare Blueprint*, plans to further explore the involvement of CM in these frameworks to take advantage of the potential benefits of CM in health management and to promote interdisciplinary collaboration in primary healthcare services. However, at present, CM treatment methods have not been included in these frameworks, and the Government has not specified a timeline for updating the relevant frameworks.

In addition, the unique treatment philosophy and methods of CM play a vital supplementary role in managing chronic diseases. However, CMPs have not been included as service providers in the Chronic Disease Co-Care Pilot Scheme (CDCC). This, to a certain extent, limits the options for treating chronic diseases and restricts the effectiveness of managing chronic conditions.

2.3 Unclear Referral Protocols Among CM Service Providers

In the future, the outpatient clinics in CMH (including referral clinic) will accept referrals from a diverse array of medical service providers, which CMH is poised to act as a central hub for referrals (Health Bureau, 2022a, 2022b). However, there is a lack of consensus on the referral arrangements among different CM service providers (CMCTRs, private CMPs and CMH). The referral criteria and mechanisms are not clearly defined, while the division of labor and roles need to be clarified.

2.4 Referral Protocols between CM Service Providers and other Healthcare Professionals to be Established

As of now, radiographers and medical laboratory technologists (MLTs) are not permitted to accept referrals from CMPs due to the Supplementary Medical Professional Ordinance (Cap. 359H), the Code of Practice for Registered Radiographers, and the Code of Practice for Medical Laboratory Technologists respectively.

However, in order to improve collaboration between CMPs and other healthcare providers and enhance the quality of CM services, there are provisional plans to allow registered CMPs to refer patients for certain imaging and laboratory tests in early 2023, by the Hong Kong Registered CMPs Association, the Hong Kong CM Specialty Development Working Group, and the Hong Kong Academy of Medicine. However, specific arrangements, amendments to the Supplementary Medical Professional Ordinance, and related codes of conduct are still pending announcement and revision.

2.5 Recommendation 3: Optimise CMCTR Operation Models

THE CONSULTATION SERVICE ASPECT

a Optimise Facility Configuration

- The Government should assess service demand and consider timely expansion of the CMCTRs and implement public-private partnership (PPP) programmes, to meet the diverse service needs of the public.

b Enhance Human Resources and Improve Promotion Ladder

- CMCTRs should establish reasonable compensation and promotion mechanisms to attract and retain experienced talents.
- CMCTRs should provide opportunities for development in teaching, research, and administration, expanding the career development paths and prospects of employees.

c Improve the Appointment Scheduling System

- Hospital Authority (HA) and CMCTRs should streamline the CM service appointment scheduling process by introducing 24-hour fully-automated telephone appointment system and improving mobile applications. Through adding non-subsidised service options and a waiting list to the appointment scheduling system, this will enhance flexibility, convenience, and efficiency of appointment scheduling, thus improving public satisfaction.

> **I often struggle to get through on the phone for appointments, unsure if it's due to full slots or line issues.
> The GOPC system is clearer,
> directly showing if appointments are booked or the line is down.**
>
> Patient focus group interviewee

d Strengthen the Management of Subsidised Quotas

- HA should establish clear and transparent criteria for the allocation of subsidised quotas based on actual needs and allow flexibility to ensure effective management of service resources.

THE TEACHING ASPECT

e Strengthen the Continuing Professional Training

- HA should collaborate with CMCTRs to assess manpower situations and develop standardised training programmes tailored for different scopes and levels, ensuring that CMPs receive ongoing standardised training.

- HA should encourage CMPs to participate in training for speciality practice, teaching, research, and administration at universities or CMH to broaden their career paths and enhance professional capabilities.
- HA should stipulate in service agreements for universities to regularly send CM professors to the CMCTRs for clinical teaching, enhancing university participation in the CMCTRs while reducing the burden on senior CMPs.

THE RESEARCH ASPECT

f Augment University Collaboration

- HA should mandate the minimal involvement of universities in clinical research project annually at CMCTRs, for example, one per year, to strengthen scientific collaboration and leverage resources.

g Relax External Research Funding and Partnership Requirements

- HA should amend service agreements to loosen restrictions on seeking external research funding and partnerships, providing CMCTRs with greater freedom to collaborate with other academic institutions and secure funding, thereby enhancing research outcomes.

2.6 Recommendation 4: Strengthen CMP's Involvement in Primary Healthcare Development

- In the short term, the Government should include CM representatives in the Expert Panel on Reference Frameworks, to ensure that CM perspectives and treatment models are incorporated during the preparation of Reference Frameworks.
- In the long term, the Expert Panel on Reference Frameworks should regularly review and update the Reference Frameworks to reflect the latest clinical research findings.
- The Government might also consider advancing the participation of CMPs in the CDCC to promote collaboration between doctors and CMPs at the primary healthcare level.

2.7 Recommendation 5: Establish Referral Protocols for CM Service Providers

- The Government should consult stakeholders to establish a clear referral mechanism from primary healthcare to specialised CM services. The Government should also consider other conditions, such as accommodating patients' medical conditions, the need for long-term observation, and research, when establishing referral mechanisms.

2.8 Recommendation 6: Define Referral Rights and Procedures Among CMPs and other Healthcare Professionals

- The Government should relax and clearly define referral arrangements with radiographers and MLTs in two phases, by requiring CMPs to undergo training and guidance, and pass relevant examinations to gain referral rights.
  - Phase One: Allow radiographers and MLTs within CMH to accept referrals from in-house CMPs.
  - Phase Two: Enable CMPs not working in CMH to refer patients to radiographers and MLTs.
- Additionally, CMPs should use the Electronic Health Record Sharing System (eHealth) to access imaging and laboratory reports and upload CM diagnostic data, ensuring information interoperability.

Figure 3 The Referral Rights and Procedures between CMPs, MLTs, and Radiographers

CMCHK and CMH:

- Relax and clearly define referral rights and procedures
- Provide appropriate training and guidance

The Radiographers Board of Hong Kong and Medical Laboratory Technologists Board of Hong Kong:

- Update their Codes of Practice

CMP:

- Pass the relevant tests
- Use eHealth

Phase 1

Enabling radiographers and MLTs in CMH to accept referrals from CMPs working in CMH

Phase 2

Allowing other radiographers and MLTs to receive CMP referrals outside CMH

3 Manpower Arrangement and Talent Development

3.1 Lack of Accurate Manpower Assessment

Over 90% of CMPs in Hong Kong provide primary healthcare services in the private market (HKSARG, 2024b). Yet, the Government does not have comprehensive data on the actual number of private CMPs and their annual service volumes. A survey conducted by the Education University of Hong Kong revealed that only 48% of CMPs had verifiable contact details (趙永佳 et al., 2020). Some CMPs are hard to reach due to clinic relocations, retirements, or deaths. Additionally, the 2020 Health Manpower Survey by the Department of Health indicated that only 19.9% of registered CMPs took part in the survey, suggesting that participation numbers do not adequately reflect the actual supply and demand for CM services (Department of Health, 2020).

3.2 Lack of Clinical Assessment Components in the CMP Licensing Examination

The licensing examination system for CMPs consists of both written and clinical components. In order to qualify for the clinical exam, candidates must first pass the written exam, which mainly focuses on CM clinical subjects (CMCHK, 2021). During the clinical exam, candidates are required to analyse cases and respond to questions verbally. However, the clinical exam does not involve direct patient interaction or the practical evaluation of the application of the four diagnostic methods (observation, auscultation, interrogation, and palpation), as well as other treatment methods such as acupuncture. This limitation prevents a comprehensive assessment of clinical proficiency.

In terms of CM education, stakeholders have noted that current CM undergraduate programmes lack systematic training plans and clinical training. The internships also lack standardised assessments to have their effectiveness evaluated, limiting students' clinical capabilities and professional development (Lee, 2024). Although local CM courses provide clinical internship opportunities, in most cases, students only observe the diagnostic process and lack sufficient opportunities to apply learned skills. This stands in contrast to western medical education, where medical students must pass clinical examinations involving patient interaction to obtain provisional registration and complete a one-year internship in hospitals to qualify for official practice. This highlights the deficiencies in CM clinical training.

3.3 Lack of Systematic Training for CMPs

Currently, the training after graduation in CM provided by various CM organisations and the CMCTRs have shown significant disparities in educational content, resources, and quality. Relying on these fragmented training channels can leave some CMPs without sufficient resources and opportunities for further education, exacerbating disparities in professional expertise among CMPs. This not only affects patient outcomes and safety, but also impacts on the overall development and image of the CM industry.

Additionally, the current healthcare system lacks a systematic primary healthcare training programme for CM. While there is a certificate course in CM primary healthcare offered by the Hong Kong Association for Integration of Chinese-Western Medicine, this single channel does not meet the entire industry's training needs (香港中西醫結合醫學會, 2022). The lack of systematic primary healthcare training not only limits the application of CM's preventative treatment philosophies within primary healthcare care services, but also hinders its integration into Hong Kong's healthcare system.

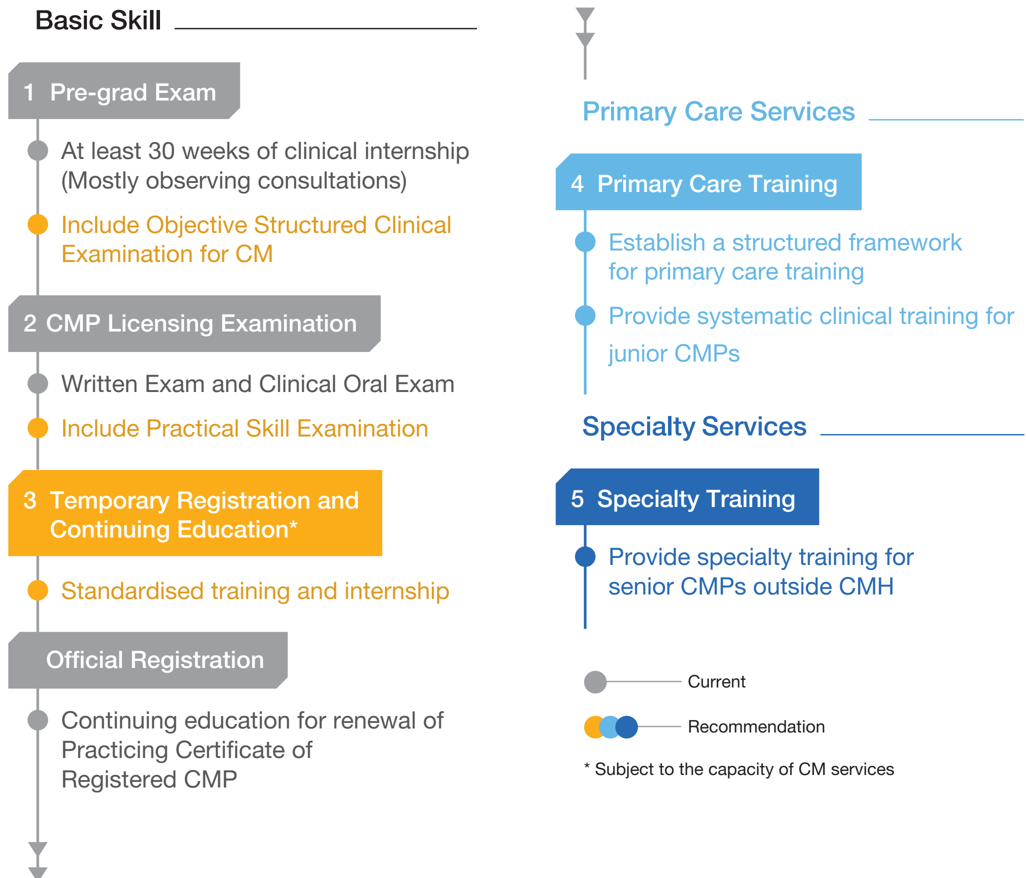
Moreover, as CMH prepares to provide specialised services, such as internal medicine, surgery, gynecology, pediatrics, orthopedics, and acupuncture, there is a notable deficiency in specialised training (Health Bureau, 2022b). While CMH is gearing up to start operations and take on the significant responsibility of specialised services, its training resources are predominantly directed towards internal staff. This approach does not adequately promote or lead professional training in CM on a broader scale.

Furthermore, the industry lacks a broad consensus on the direction and pathways for professional development in CM, making it difficult for training institutions and curriculum to precisely align with the needs of the healthcare system. Therefore, effectively integrating resources from CMH, accredited continuing education institutions, and universities to develop a unified and applicable training system for CM in Hong Kong remains a critical issue.

The current examination system only consists of written and oral examinations. It does not assess the ability of clinical practice, which results in many graduated CMPs not knowing how to apply clinical skills.

Chief of Service of CMCTR

Figure 4 Recommended Training Model



3.4 Recommendation 7: Evaluate the CM Manpower to Facilitate Service Planning

- Hong Kong should implement a comprehensive manpower survey of CMPs, to accurately estimate the number of practicing CMPs and the service demand for the development of strategic purchasing plans.
- CMCHK should update the protocols for renewing practicing certificates of registered CMPs, including mandatory updates of contact information during Continuing Education in CM (CME) training enrollments and Practicing Certificate renewals, encouragement of participation in eHealth, and continuous update of CM manpower.

3.5 Recommendation 8: Review the Current CMP Licensing Examination

- Drawing from practices in mainland China and the Objective Structured Clinical Examination (OSCE) model for CM, the CM sector should collaborate with universities to reform the Licensing Examination by introducing clinical assessments, to ensure students' clinical decision-making skills.
- Subject to the capacity of CM services, CM students should complete a one-year internship before applying for full registration.

3.6 Recommendation 9: Enhance Systematic Continuing Education and Training

- The Primary Healthcare Commission should develop a comprehensive framework for regular CM training, focusing on health education, general CM services, and resident health management, drawing on the standardised training model from Mainland China.
- The Government should collaborate with the CMCTRs and non-governmental organisations to provide mobile CM clinic services, enhancing training and practice opportunities for CMPs.

> **Many CMPs do not know they are providing primary healthcare services. Through systematic primary healthcare training, the industry can better integrate with the primary healthcare system, and collaborate with other healthcare professionals.**
>
> **Staff of CMCTR**

- CMH should collaborate with the Chinese Medicine Practitioners Board of CMCHK, the accredited CME Programme Providers and local universities, to establish a strategic training framework for comprehensive and uniform curriculum, training systems and assessment mechanisms. As such, practicing CMPs and CM students can deepen their mastery of CM theories and specialised practice, while also enhancing understanding of the modern healthcare system, hospital operations, and management of CM service organisations.
- CMH should open their specialised training courses to non-affiliated CMPs to promote professional training and enhance clinical competencies of CMPs.

4 Utilisation of Available Resources for Strategic Purchasing

4.1 Limited Healthcare Financing Mechanisms

Compared to western medicine, the current healthcare financing methods for CM are considerably limited. While western medicine utilises a diverse range of financing methods, including Government-funded services, EHVS, and out-of-pocket payments, citizens can also opt for services using Voluntary Health Insurance Scheme (VHIS). Additionally, many choose to purchase private medical insurance for broader coverage when needed. In contrast, CM primarily relies on more restricted financing methods: subsidised services at CMCTRs, EHVS, and out-of-pocket payments. At the same time, CM services are not covered in the VHIS Standard Plan according to the Government's Certified Plan Policy Template. Currently, the Government supports citizens in accessing subsidised CM treatment with 800,000 annual subsidised outpatient consultation quotas at CMCTRs. Additionally, the Government also subsidises elderly medical services, including CM service, through EHVS.

4.2 Potential of Private Service to Be Explored

Over 90% of CMPs opt to work in the private sector, highlighting an uneven distribution of resources between public and private sectors. This not only limits the overall efficiency of CM services but also poses challenges to the sustainability of the healthcare system.

CMCTRs often face considerable service pressure due to limited resources. Conversely, private CM clinics operate as if they are independent from the healthcare system, and may not be able to fully align with the development direction of the system. Meanwhile, private CM clinics also encounter issues like insufficient patients and underutilisation of equipment. There might even be excessive competition among private clinics, leading to unnecessary resource overlap and waste.

> **Adding more subsidised quotas (to CMCTRs) would encounter challenges resulting from limited consultation rooms and manpower. It is better to consider giving the quotas to private services. The pilot programme could start with those NGOs with their own clinics and operation experience of CMCTRs.**
>
> Staff of CMCTR

4.3 Recommendation 10: Adopt a Multi-Pronged Approach to Healthcare Financing

- The Government should explore diversified healthcare financing models, such as collaborating with insurance companies to increase the insurance coverage amount and area for CM services.
- Drawing on South Korea's national health insurance policies related to Korean medicine, the Government should include CM services in VHIS Standard Plan to promote insurance coverage.
- Drawing on Taiwan's experience, the CM Clinical Expert Panel should work with the insurance industry to define the specific level of details required for diagnosis and treatment information on insurance claims. The insurance industry should also employ CMPs to participate in insurance audits to ensure the reliability of diagnoses.

4.4 Recommendation 11: Leverage Private CMPs for PPP

- The Government should strategically purchase private CM services. By focusing on disease areas that CM has advantages, it can promote PPP for more accessible subsidised CM services while alleviating the long waiting time issue in the public healthcare system.
- The Government should establish a public-private patient referral mechanism between CM and western medicine through eHealth, ensuring seamless transition between different treatment settings.
- The Government should formulate and implement quality standards and regulatory guidelines for CM clinics, and establish a patient feedback mechanism, to ensure service quality and patient safety, and continuous service improvement.
- The Government should incorporate CM into CDCC, based on clinical guidelines developed by the CM Clinical Expert Panel, to promote interdisciplinary collaboration and provide personalised treatment options.

5 Promotion of Information Sharing

5.1 Suboptimal Usage Rate for eHealth in CM

Despite the integration of CM electronic health records (including HA's Chinese Medicine Information System (CMIS) and EC Connect developed for private CM clinics) with eHealth since March 2022, the adoption within the CM sector remains limited. According to data from the Hong Kong Legislative Council, as of March 2023, only about 640 CMPs, or 6%, are registered with eHealth (HKSARG, 2023c).

5.2 Limited Scope of eHealth Information Shared with CMPs

The scope of interoperability for electronic health records in CM is currently limited. As shown in Table 1, within the CM sector, the information related to diagnosis that can be shared includes only CM diagnosis, treatments, and prescriptions. Other essential data such as patient's chief complaints and medical history are not included in the scope of exchange (醫管局中醫部, 2022). Additionally, the range of medical data from other sectors that CMPs can access is restricted. Compared to the data access available to other healthcare professionals (Table 1), CMPs can only access personal identification, allergies and adverse drug reactions, CM diagnosis, treatments, prescriptions, and information on hospitalisations, clinic visits, and appointments (醫管局中醫部, 2022). They do not have access to referral records, examination reports, and other data accessible to other healthcare professionals, thus creating information barriers that subsequently affect the quality and efficiency of healthcare services.

It is imperative to acknowledge that most private CMPs primarily rely on patients for the submission of imaging and laboratory testing results. For example, for patients with kidney disease, CMPs need to refer to the patient's glomerular filtration rate (GFR). Nonetheless, concerns have been raised by certain stakeholders highlighting the internal guidelines of the HA pertaining to the Integrated Chinese-Western Medicine services, stipulating that CMPs should refrain from prescribing certain medications when a patient's glomerular filtration rate falls below a specified threshold. Owing to the unavailability of pertinent data accessible to private CMPs, the sole reliance on patient-provided information may lead to inaccuracies resulting from errors in recollection or transcription. This not only leads to diagnostic delays but also causes duplication and unnecessary risks during treatment. Thus, the absence of comprehensive medical records may limit the capacity of CMPs to conduct a thorough assessment and deliver comprehensive treatment addressing the patient's holistic condition.

Table 1 Scope of eHealth Sharable Data among Different Healthcare Professionals

	CMPs	Doctors/ Midwives/ Nurses/Dentists	Pharmacists/ Optometrists (Part 1)	Occupational Therapists/ Physiotherapists	Radiographers	MLTs
Personal identification and demographic data	Ordinary control	Ordinary control	Ordinary control	Ordinary control	Ordinary control	Ordinary control
Allergies and adverse drug reactions	Ordinary control	Ordinary control	Ordinary control	Ordinary control	Ordinary control	Ordinary control
Observation and lifestyle records	Ordinary control	Ordinary control	Ordinary control	Ordinary control	Ordinary control	Ordinary control
Diagnosis	Restricted control; Only CM-related records	Ordinary control	Ordinary control	Ordinary control	Restricted control	Restricted control
Procedures	Restricted control; Only CM-related records	Ordinary control	Ordinary control	Ordinary control	Restricted control	Restricted control
Medications	Restricted control; Only CM-related records	Ordinary control	Ordinary control	Ordinary control	Restricted control	Restricted control
Encounters and appointments	Ordinary control	Ordinary control	Ordinary control	Ordinary control	Restricted control	Restricted control
Clinical note / summary	Restricted control ▲	Ordinary control	Ordinary control	Ordinary control	Restricted control	No access
Immunisation records	Ordinary control	Ordinary control	Ordinary control	Ordinary control	Restricted control	Restricted control
Laboratory reports	No access	Ordinary control	Ordinary control	Restricted control	Restricted control	Ordinary control
Radiology reports	No access	Ordinary control	Restricted control	Ordinary control	Ordinary control	Restricted control
Healthcare referrals	No access	Ordinary control	Ordinary control	Ordinary control	Ordinary control	Ordinary control
Birth records	No access	Ordinary control	Restricted control	Restricted control	No access	Restricted control
Other investigation reports	No access	Ordinary control	Restricted control	Restricted control	Restricted control	No access

Remarks: ● Ordinary control ● Restricted control ● No access
Only CM-related records can be accessed ▲ Only records of specific programmes can be accessed

Source: eHealth (2023)

5.3 Recommendation 12: Incentivise CMPs to Join Primary Care Directory and Use eHealth

- The Government should require all CMPs participating in Government-funded healthcare service programmes to join the Primary Care Directory and use eHealth to improve service coordination and coherence.
- The Government and system developers should address the difficulties faced by healthcare providers in using eHealth. They should optimise the system's user interface and functionality, and improve the system's interoperability with third-party clinic management systems and eHealth, to enhance the system's usability and performance.

Many CMPs think it is troublesome to input clinical records in two systems. If the Government can enable automatic transfer of records from third-party clinical management systems to eHealth with patients' consent, it will facilitate more CMPs to use eHealth.

Private CMP

5.4 Recommendation 13: Adopt a Patient-Centred Approach for the Expansion of the Scope of Information Sharing

- Based on the principles of "patient-under-care" and "need-to-know", the Government should expand the access of CMPs to medical records, including imaging and laboratory results, to enhance diagnostic accuracy.
- The Government should increase professional training related to the use of medical records and associated legal responsibilities for CMPs to promote collaboration with other healthcare professionals.

6 Create a Platform for Medical Innovation and Clinical Research

6.1 Fragmentation of Research Resources

The resources for clinical research in the field of CM appear to be fragmented. Universities, CMDF, and HA each have their strengths, but opportunities for collaboration are few. This has led to many research outcomes not being effectively translated into local CM clinical practice.

In terms of research application, the current resource platform under CMDF provides the CM community with relevant resources and practical reference documents, such as electronic pharmacopoeias, CM-related journal databases, and policies and regulations (中醫藥發展基金, n.d.). However, these databases are predominantly from mainland China and do not cover local research data. In Hong Kong, CMPs are required to use purely traditional methods, unlike their Mainland counterparts who may use a combination of Chinese and western medicine. Therefore, the platform's data have limited applicability and are not effectively used in actual treatment and research.

6.2 Stagnant Development on CM Telemedicine

During the COVID-19 pandemic, telemedicine became popularised. The Food and Health Bureau, through CMDF, launched the "Fight the Virus Together—Chinese Medicine Telemedicine Scheme", subsidising CMPs to provide patients with free telemedicine diagnosis, treatment, and drug delivery services. This not only helped alleviate patients' symptoms, but also promoted the popularisation of CM and CM telemedicine (HKSARG, 2022d).

At the same time, despite the Government’s increase of subsidised quotas for the CMCTRs, citizens have reported that booking CM services remains challenging. This demonstrates that the service capacity of the CMCTRs is limited by hardware constraints. Therefore, incorporating telemedicine services in CMCTRs could help alleviate the pressure brought by the increased service funding. However, after the pandemic, the development of telemedicine in CM has stagnated, and CMCTRs have not been able to continue offering telemedicine services.

6.3 Recommendation 14: Create a Cross-Sector R&D Platform

- The Government should establish a cross-sector R&D platform to promote collaboration among the CMDF, universities, Government Chinese Medicines Testing Institute, HA, and other key stakeholders. The platform should focus on the following five functions to consolidate resources for conducting CM clinical research and applying the research findings in commercial and service settings.

Figure 5 Potential Development of the R&D Cooperation Platform

A Cross-Sector R&D Cooperation Platform

- Promote multi-party collaboration among the CM industry
- Enhance Synergy

a) **Research Funding Integration:** Centralise and optimise funding allocation to avoid duplicate resource investment.

b) **Patient Matching:** Establish an online system to collect and publish information on clinical studies, facilitating the matching of patients with clinical research projects.

c) **Knowledge Exchange:** Promote knowledge sharing between universities, research institutions, CMCTRs, CMH, and pharmaceutical companies through organising local and international seminars and forums.

d) **Knowledge Transfer and Commercialisation:** Set up an office to assist in the commercialisation of research outcomes, international market registration, and promotion.

e) **Quality Assurance:** Collaborate with the Hong Kong Standards and Testing Centre and other research institutions to establish and promote a strict quality control system.

6.4 Recommendation 15: Promote the Provision of CM Telemedicine Services

- The Government should require CMCTRs to incorporate telemedicine services, establishing relevant guidelines and standards to ensure service quality and safety.
- CM organisations and associations can also offer training courses on using remote communication platforms for diagnosis and treatment to effectively provide CM telehealth services.

Conclusion

As Hong Kong's population ages, chronic diseases become more prevalent, and CM services have gained widespread attention and recognition, it is time to enhance the role of CM in the healthcare system and promote CM's system development. This is crucial in building a sustainable and integrated healthcare system with Chinese and Western medicine.

To fully realise CM's potential for development in Hong Kong, enhancements are needed in several areas, including governance, services, human resources, healthcare financing, health information systems, and medical technology and clinical research. Through addressing these areas, CM can better leverage its unique advantages to provide higher quality and more comprehensive healthcare services to the residents of Hong Kong.

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