Part I

Legitimation and Perception

1

Development and Regulation of Traditional Chinese Medicine Practitioners in Hong Kong

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In response to the increasing popularity of traditional, complementary, and integrative medicine (TCIM) worldwide (Harris & Rees, 2000), the World Health Organization (WHO) launched the Traditional Medicine Strategy 2002–2005 (WHO, 2002) emphasizing the development of national TCIM policies among member states. In 2005, the WHO conducted a global survey on TCIM development and found that 45 of the 141 (32%) responding member states had national TCIM policies, while 51 (56%) were contemplating such development (WHO, 2005). One major element of these policies is the regulation of practitioners, and this issue is high on the policy agenda of many developed countries, including the United Kingdom (Stone, 2005), Australia (Carlton & Bensoussan, 2002), Canada (Moss, Boon, Ballantyne, & Kachan, 2007), and the United States (Eisenberg et al., 2002).

In the West, the profile of TCIM rose as part of its renaissance in the late 1990s, spurred by dissatisfaction with conventional Western biomedicine (WM) as well as a growing exploration of global ideas.

TCIM popularity has since persisted in many countries. For instance, the 2012 survey reported in the WHO *Traditional Medicine Strategy: 2014–2023* (WHO, 2013) estimated that 103 of the 129 (80%) member states recognized the value of therapeutic acupuncture, which is a key TCIM intervention. The increasing acceptance of acupuncture is reflected by its growing demand in countries such as the United States and Australia in the past decade (Su & Li, 2011; Australian Bureau of Statistics, 2008). However, in other parts of the world, both history and culture have shaped a different course and perspective on TCIM. In Hong Kong, for example, the initial policy interventions regulating TCIM practices can be dated back to the mid-19th century and were followed by a number of notable milestones with regards to regulation and professionalization (Table 1.1).

Traditional Chinese medicine in Hong Kong: A history of government regulation

Hong Kong was a British colony for over 100 years, and the introduction of WM to Hong Kong and southern China by missionaries in the late 19th century likely overlapped with this period (Xie, 1998). However, although WM was considered the formal healthcare system, traditional Chinese medicine (CM) remained the medical care of choice for most of the population because of its accessibility, affordability, and cultural appropriateness. Despite CM's wide usage, the British colonial government adopted a laissez-faire policy towards it. It was treated as an indigenous custom and was, therefore, monitored by the Secretary for Home Affairs instead of the Secretary for Health. Notably, this unrestrictive, and somewhat dismissive, attitude of the government towards CM continued for most of the 20th century. One of the few instances of government intervention occurred when sanctions were brought against the CM practice in 1894 after health officials deemed CM

to be "incompetent" in managing the plague epidemic (Xie, 1998). The perceived need for development further declined during the Japanese occupation in World War II, as the popularity of CM decreased when many Chinese medicine practitioners (CMPs) and clients returned to Mainland China. In the post-war period, CM practice continued only in small private settings (Xie, 1998), again with limited government intervention.

The situation in colonial Hong Kong contrasts starkly with that in Mainland China, which implemented policies promoting the coexistence and integration of CM and WM in the 1950s (Taylor, 2005). Today, the WHO recognizes Mainland China as the first healthcare system in the world to fully integrate TCIM and WM at all levels of care (WHO, 2002). Mainland China's latest healthcare reform proposal, for example, specifically highlights CM's potential role in tackling the burgeoning problem of chronic non-communicable diseases within its ageing population (National Development and Reform Commission of China, 2008). Thus, it is not surprising that under the influence of Beijing's long-established national CM policies, Hong Kong's reunification with Mainland China on 1 July 1997 signified the end of stagnation in CM development in the region (Chiu, Ko, & Lee, 2005). The impetus for legislative change had also become apparent in the last decade of colonial rule, highlighted by Basic Law Article 138 (outlined in 1990 and enacted in 1997), and following the handover, the first Chief Executive of the Hong Kong Special Administrative Region (HKSAR) also announced the government's initiatives for further CM development. A consultative document on the issue was published in the following month, and CM's role in the Hong Kong healthcare system was officially recognized for the first time after 100 years of marginalization. The Chief Executive's policy addresses of 2001 and 2005 as well as the 2007 election manifesto of the second Chief Executive re-emphasized similar top-down commitments (Chief Executive Officer, 2001; 2005;

Table 1.1 Milestones in the development of traditional Chinese medicine practitioners (CMPs) in Hong Kong

Date	Summary of events
Jan 1989	While drafting of the constitutional laws of postcolonial Hong Kong (Basic Law), was initiated in January 1989, the legal foundation of CM development was not laid until April 1990. Article 138 of the Basic Law states: "The government of the Hong Kong Special Administrative Region shall, on its own, formulate policies to develop Western and traditional Chinese medicine and to improve medical and health services. Community organizations and individuals may provide various medical and health services in accordance with the law."
Aug 1989	The Working Party on Chinese Medicine was launched to conduct the first public review on CM.
1995	Under the requirements set by the Secretary for Health and Welfare, the Preparatory Committee on Chinese Medicine was formed to draft post-handover regulatory plans concerning CM.
Sept 1995	A total of 6,890 CMPs took part in the "Enrollment of Chinese Medicine Practitioners in Hong Kong" organized by the Preparatory Committee on Chinese Medicine. The information collected was used to develop future criteria for registration.
1998	The Hong Kong Baptist University founded the first full-time five-year undergraduate CM degree program, followed by similar programs launched by the Chinese University of Hong Kong in 1999 and the University of Hong Kong in 2000.
July 1999	The Chinese Medicine Ordinance was passed by the HKSAR Legislative Council.
Sept 1999	The Chinese Medicine Council of Hong Kong (CMCHK), a statutory body responsible for implementing regulatory measures, was set up under the Chinese Medicine Ordinance. The Chinese Medicine Practitioners Board and the Chinese Medicines Board were also established under this Council.

Table 1.1 (continued)

Date	Summary of events
Dec 2001	A list of 7,707 "listed" CMPs was published in the Gazette. During the transitional period, both registered and listed CMPs were allowed to practice legally. Among them, only registered practitioners were allowed to prescribe Schedule 1 Chinese herbal medicines according to the Chinese Medicine Ordinance. Notably, the status of listed practitioners is transitional, as each is eventually expected to become a registered via assessment or examination.
June 2002	The first list of 2,384 registered CMPs was published in the Gazette.
2003	The first licensing examination for CMPs was held. Upon passing the licensing examination, listed CMPs or fresh CM graduates could attain registration status.
2005	The first batch of locally trained CM students graduated. The Continuing Chinese Medicine Education (CME) program was launched. CMPs must earn 60 CME points in three years to renew their licenses.
2008	Amendments to labor laws enabled registered CMPs to certify sick leave arising from work injuries.
Feb 2013	The Chinese Medicine Development Committee (CMDC) was established. It was charged with identifying directions, goals, and strategies related to CM services, research, and industry as well as the professional development of practitioners. Two sub-committees were set up under the CMDC: the Chinese Medicine Practice Sub-committee and the Chinese Medicines Industry Sub-committee.
Sept 2014	Phase I of the Integrated Chinese-Western Medicine Pilot Programme was launched for inpatients in three disease areas in three hospitals under the Hospital Authority.
Dec 2015	Phase II of the Integrated Pilot Programme was launched (included four more hospitals).
April 2018	Phase III of the Integrated Pilot Programme was launched (included a new disease area).

2007). Furthermore, the 2017 policy address of the Chief Executive contained additional government initiatives related to CM (Chief Executive Officer, 2017). These include the establishment of a unit under the Food and Health Bureau to oversee CM development and regulation as well as a government-run Chinese herbal medicine testing institute (Health, Welfare and Food Bureau and the Hospital Authority, 2005). Ultimately, these initiatives will be implemented as a way to develop Hong Kong into an international hub for scientific research on CM testing and quality control.

Promoting CM development via practitioner regulation

Over the last decade, the primary focus of CM development has been on the regulation and professionalization of CMPs. There have been three notable achievements during this time: (1) the introduction of licensing requirements for CMPs via the formation of an official regulatory body (Chinese Medicine Ordinance, 1999); (2) the formalization of CM education by establishing degree programs at Hong Kong Baptist University, the University of Hong Kong, and the Chinese University of Hong Kong; and (3) the launch of the Continuing Chinese Medicine Education (CME) program as a license revalidation requirement (Chinese Medicine Council of Hong Kong [CMCHK], n.d.). The regulatory program established for Hong Kong's CMPs was designed to clarify the qualifications of existing CMPs, protect the public from unsafe practices, and promote professional and ethical conduct among CMPs (Saks, 2002). In addition to these achievements, formal regulation of CM services resulted in increased utilization by the public (Chung, Wong, Woo, Lo, & Griffiths, 2007; Leung et al., 2005). Following this surge in use and acceptance, the Employees' Compensation Ordinance was amended to entitle registered CMPs to issue legally recognized medical (sick leave) certificates (Labour Department, HKSAR,

2006), a gesture that increased patient choice and further promoted system integration. In 2008, further amendments were also made to include recognition of treatments, examinations, and certifications given by registered CMPs for workplace injury and medical expense reimbursement (Labour Department, HKSAR, n.d.).

Taken together, these regulations, and the CMP empowerment resulting from them, have transformed practitioners into a new group of independent primary care providers that practice alongside their WM colleagues. Unfortunately, these measures have failed to address the broader impact of professionalization, especially in the relationship between CMPs and WM-trained professionals and the delivery of integrated patient care.

Integrating CM and WM

Although CM and WM are now practiced in parallel in Hong Kong, two separate statutory bodies regulate CMPs and WM doctors (WMDs), and there is currently no communication platform established between the two professions. Discrimination towards CM by WMDs is long established (Holliday, 2003), and the effects of regulation on the attitudes of WMDs towards CMPs remains unknown. To further compound this, CM services are still mainly provided in private outpatient settings, and referral from the CM sector to the WM-focused public healthcare system is not accepted unless it is associated with designated programs. This professional and systematic compartmentalization of CM and WM is not in line with the public's utilization pattern, in which "double-consultations" with both a CMP and a WMD is common practice (Chung et al., 2007). Policy initiatives to bring WM and CM together under a common primary care infrastructure are required to ensure the continuity, coordination, and comprehensiveness of primary care services, regardless of medical paradigm. Notably, some progress

has been made to achieve this, and CM clinics have been established within the public healthcare system to promote integration using a scientifically supported "evidence-based" CM approach. For example, the Hospital Authority has established a total of 18 Chinese Medicine Centres for Training and Research (CMCTRs), one in each of the 18 districts of Hong Kong. These CMCTRs operate on a tripartite collaboration model that involves the Hospital Authority, nongovernmental organizations (NGOs), and local universities, with the NGOs being responsible for the day-to-day operations at each facility (Hospital Authority, 2018).

Experience from Hong Kong suggests that the parallel regulatory systems of CM and WM do not promote service coordination or integration (Dixon, Peckham, & Ho, 2007) nor do they contribute to patient-centered care or patient choice. To promote the role of CM in the Hong Kong health system, and to promote collaboration between CM and WM clinicians, more top-down policy changes have been initiated by the government in recent years. For example, the Chinese Medicine Development Committee (CMDC), chaired by the Secretary for Food and Health, was established in February 2013 to provide recommendations concerning the future direction and long-term strategy of CM development in Hong Kong. As set out in the 2016 Chief Executive Policy Address, the Hong Kong Government will also establish a CM hospital in Tseung Kwan O (Chief Executive Officer, 2016). To gather experience on how the future hospital may operate, the Hospital Authority has launched the Integrated Chinese-Western Medicine Pilot Programme (Hospital Authority, 2017). This program provides integrated Chinese-Western medicine treatment for patients receiving cancer palliative care, stroke rehabilitation, and lower back pain treatment. Moreover, according to the 2017 Chief Executive Policy Address, the new CM hospital will be operated by a non-profit organization supervised by the government and the Hospital Authority. However, the financing for this hospital has yet

to be determined (Chief Executive Officer, 2017). At publication, no new information concerning the establishment of this hospital is available. The government also recently proposed increased spending in the CM sector in the 2018 budget (Financial Secretary, 2018), and an HK$500 million fund will be established to support CM specialization, applied research, and knowledge exchange.

An alternative approach to regulation

The history and regulation of CM in Hong Kong and Mainland China has likely impacted both its utilization and integration. Indeed, the effects are most apparent when compared to those of CM regulation and integration in the West. In the United Kingdom, for instance, a systematic review of methodologically sound survey results published from 2000 to 2011 estimated that the average 1-year prevalence of TCIM use in the population was 26.3% and the average lifetime prevalence was 44.0% (Posadzki, Watson, Alotaibi, & Ernst, 2013). Notably, compared to the Hong Kong model, the United Kingdom Department of Health has taken an alternative direction by recommending that the statutory regulation of TCIM practitioners "should take place through existing regulatory bodies", such that the workforce development of TCIM practitioners will be concordant with the "increased emphasis on inter-professional team working" (Department of Health, 2008). These directions are in line with the initiatives mentioned in the white paper *Trust, Assurance and Safety — the Regulation of Health Professionals in the 21st Century* (Secretary of State for Health, 2007), which argue that "regulators with a number of professions are more aware of the interface between different professions' practice" (p. 85). This arrangement is also thought to promote "multidisciplinary working to support integrated services to meet service users' needs" (p. 85). If these assumptions are valid in the case of WM and TCIM, this

approach to regulation may provide a stronger basis for integration in the United Kingdom. However, as the influence of regulation on integration is not fully known (Dixon, 2008), strategies that go beyond regulation are required to foster integration, in both the United Kingdom and Hong Kong.

Conclusion

Colocalization and organizational coordination between WMDs and TCIM practitioners may represent partial solutions in ensuring quality and continuity of patient care. Long-term planning to address the structural and financial questions involved in promoting teamwork between WMD and TCIM practitioners is also essential to ensure the sustainable development of high-quality, safe, and integrated patient care. Therefore, while practitioner development and regulation has seemingly enhanced the use and perception of TCIM by clients, the professionalization and acceptance of practitioners by their WM counterparts is lagging. The means to address these issues will likely stem from a combination of continued government regulation and legitimation, increased practitioner education, and enhanced public perception.

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