香港物理治療師協會
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Dr. PANG Fei Chau

Commissioner for Primary Healthcare

Primary Healthcare Commission

Health Bureau

The Government of the Hong Kong Special Administrative Region

22 Jan 2026

<u>Highly Concerns About the Narrowing of Direct Access Physiotherapy Implementation and Associated Operational Consequences</u>

Dear Dr PANG,

I write on behalf of the Hong Kong Physiotherapists' Union (HKPU) regarding the "Clinical Guideline for First-Contact Physiotherapists on Assessment and Cross-disciplinary Management Approach for Common Musculoskeletal Problems in Primary Care Setting" (first published in December 2025) ("the Guideline"). We acknowledge the effort required to produce a discipline-based guideline under the Hong Kong Primary Healthcare Reference Framework (HKPRF). Unfortunately, the way the current framework is being operationalised has created the impression that "direct access" is being introduced with considerable formality, but with a scope and workflow narrower and slower than those represented to the community and the profession during the legislative process.

HKPU therefore seeks PHCC's explanation on the following matters, not as an academic exercise, but because the present approach risks turning a reform intended to remove barriers into a new set of barriers with improved branding.

To begin with, HKPU would be grateful if PHCC could explain to why the implementation now appears to retreat from the policy intent stated during the Legislative Council Bills Committee deliberations on 22 Apr, 13 May and 22 May 2025. We note from the meeting record that the Health Bureau expressly stated that the first phase clinical guidance would cover musculoskeletal conditions and "would not be confined" to only low back pain, nor "confined" to individual body parts, and that the scope would expand progressively. Yet in the Guideline, the direct access pathway "for a condition stipulated by clinical guidelines" under HKPRF is described, at present, as covering only **osteoarthritis of knee** and **low back pain**. In practical terms, many frontline practitioners have understood this as a de facto restriction that renders the "clinical guideline" circumstance largely synonymous with only two conditions. If this narrowing is a deliberate policy choice, HKPU respectfully requests PHCC to state plainly what changed between the statements made to the legislature and the present operational scope, who authorised this change, and on what patient-safety or system-capacity evidence the change is grounded. If, on the other hand, PHCC considers the present position consistent with what was said on 22 Apar, 13 May and 22 May 2025, we would be grateful if PHCC could explain how a scope described in practice as two conditions should be read as "not confined" in any meaningful sense.

Secondly, HKPU would also appreciate PHCC explaining how the present emphasis on a small number of pain-labelled conditions is compatible with the preventive rationale repeatedly cited for direct access in primary healthcare. The Guideline itself recognises that physiotherapy management in primary care is not merely "pain treatment" and is explicitly framed around function. In **Table 3.2**, the Guideline lists common musculoskeletal problems that can be effectively managed by physiotherapy, including: **"Mechanical back pain"**, **"Mechanical neck pain"**, **"Shoulder pain"**, **"Elbow pain"**, **"Wrist and hand pain"**, **"Hip pain"**, **"Knee pain"**, and **"Ankle and foot pain."** The corresponding treatment modalities in the same table are likewise functional in nature, including **education and ergonomic advice**, **exercise therapy** and **functional training**, as well as physical modalities and manual therapy.

In other words, the Guideline's own clinical logic is anchored in restoring movement and function, addressing activity limitation, and preventing progression, precisely the preventive intent of primary healthcare. If direct access is implemented in a way that effectively channels timely physiotherapy only to two conditions, while leaving other common functional-limiting presentations to wait for medical routing, then direct access risks being reduced to a "pain-label gatekeeping exercise" rather than an early-intervention pathway. HKPU respectfully requests PHCC to explain how such an approach aligns with the stated rationale in the Guideline that early access reduces sickness absence, accelerates recovery, and improves long-term wellbeing, and how it avoids contradicting the preventive purpose of intervening before functional decline becomes chronic.

Thirdly, HKPU remains concerned about the endorsement workflow under the PHCC cross-disciplinary collaboration arrangement, particularly as described in Figure 3.3 and paragraphs 3.2.19 to 3.2.23 of the Guideline. Under this arrangement, once a physiotherapist notifies the paired family doctor via eHealth, the family doctor is to review the referral letter or assessment record within **2 working days**, and the endorsement is to be made within **7 working days**. While this is presented as a mechanism to enable "timely appropriate treatment", the cumulative effect is that a patient may wait up to **9 working days** before physiotherapy may be initiated, with the physiotherapist permitted only to provide education and management advice in the interim. Under this arrangement, it is reasonable to foresee that patients will seek a doctor's referral before consulting a physiotherapist. This behavior deviates from the original intent of the direct access policy for physiotherapy.

In real-world primary care, this creates a predictable tendency. After waiting up to 9 working days, it is highly likely the doctor will decide that the patient should consult the doctor first before endorsing anything. That effectively converts the pathway into a "doctor appointment first" process, merely delayed by an administrative interval. The patient experiences delay, the doctor's clinic list grows, and the physiotherapist's professional autonomy is reduced to drafting a case note designed for endorsement rather than delivering timely care. This sequencing appears to convert "direct access" into "delayed access", now with an electronic timestamp.

HKPU therefore appreciates PHCC's explanation of how PHCC determined that this delay is clinically acceptable for common musculoskeletal problems in the community, what monitoring indicators PHCC will use to evaluate the impact of endorsement turnaround time on patient outcomes and service utilisation, and whether PHCC will revise the workflow so that clearly within-scope, low-risk interventions can proceed without waiting for a non-urgent endorsement, while still ensuring prompt medical involvement when red flags, diagnostic uncertainty, contraindications, or poor treatment response arise, as already stipulated elsewhere in the Guideline.

HKPU fully supports patient safety and cross-disciplinary collaboration in principle. However, the profession is entitled to expect that an arrangement described publicly as a reform to improve access and prevention will not be implemented in a manner that narrows the scope, delays care, and then relies on physiotherapists to reassure the public that the system is working as intended. HKPU would therefore appreciate PHCC's written explanation addressing the above matters and setting out the concrete policy basis, evidence base, and implementation timetable for any intended expansion beyond the present limitations.

Yours sincerely,

Kenneth Au Yeung

President

Hong Kong Physiotherapists' Union (HKPU)

c.c.:

● Prof. LO Chung Mau (Secretary for Health, Health Bureau, The Government of HKSAR)

● Dr. FAN Yuen Man Cecilia (Under Secretary for Health, Health Bureau, The Government of HKSAR)

● Ms. MAK Tse Ling Elaine (Deputy Secretary for Health 3, Health Bureau, The Government of HKSAR)

● Dr. LAM Man Kin, Ronald, JP (Director of Health, Department of Health)

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● Panel on Health Services Legislative Council 2026