立法會
Legislative Council

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Report of the Panel on Health Services
for submission to the Legislative Council

Purpose

This report gives an account of the work of the Panel on Health Services during the 2000-2001 Legislative Council (LegCo) session. It will be tabled at the LegCo meeting on 4 July 2001 in accordance with Rule 77(14) of the Rules of Procedure.

The Panel

2. The Panel was formed by a resolution passed by the Council on 8 July 1998 and as amended on 20 December 2000 for the purpose of monitoring and examining Government policies and issues of public concern relating to health services matters.

3. The terms of reference of the Panel are in **Appendix I**.

4. The Panel comprises 11 members, with Hon Mrs Sophie LEUNG LAU Yau-fun and Dr Hon LO Wing-lok elected as Chairman and Deputy Chairman of the Panel respectively. The membership list of the Panel is in **Appendix II**.

Major work

Consultation Document on Health Care Reform

5. Following the release of the above consultation on 12 December 2000, the Panel discussed in detail the reforms to the service delivery system, the system of quality assurance and the options for financing health care service at three subsequent meetings.

6. In regard to the reforms to the service delivery system, members supported the proposals to strengthen preventive care and develop a network of

community-based integrated health care services. They agreed that well-designed ambulatory and community care programmes could help shorten the length of stay in hospitals by continuing the treatment and care in the community. In response to members' concern that some patients' homes might not be suitable for convalescence due to their cramped living environment, the Administration said that no patients would be asked to leave the hospitals to continue their treatment and care in the community if their homes were not suitable for convalescence and/or did not have family members to take good care of them.

7. As to the proposed transfer of the Department of Health (DH)'s general out-patient service to the Hospital Authority (HA), members were concerned that such a move would not only increase the already heavy workload of HA but also aggravate the present uneven distribution of workload between the public and private sectors. The Administration explained that the proposed arrangement would facilitate continuity of care through the primary and secondary levels in the public sector. In addition, the clinics to be transferred would serve as the training ground for family medicine and other primary care practice.

8. As regards members' concern about the wide gulf between the fees of the public and private sectors which had resulted in the public sector taking up 93% of the workload, the Administration said that HA would explore with the private sector how both sides could collaborate and develop health care products with a view to providing patients with more choices in medical treatment. The insurance industry would be encouraged to develop new health care insurance policies to support these new products. The Administration would provide the insurance sector with relevant statistics for assessment of underwriting such new policies and further discuss with the sector in this regard.

9. On the financing of the public health care system in future, the Administration assured members that it would continue to invest in public health care service based on the new population-based funding arrangement agreed with HA. At the same time, it would adopt a number of cost-control measures including rationalisation of service delivery network to minimise duplication, improvement of productivity through service re-design, and development of clinical protocols to guide appropriate application of services and investigations. In addition to revamping the fees structure, the Administration also proposed to establish a Health Protection Account (HPA) scheme to strengthen the long term sustainability of the public health care system.

10. Most members objected to the proposed HPA scheme, given that the economy had not yet fully recovered and that the working population had just

started to contribute 5% of their salaries to the Mandatory Provident Fund Scheme. The Administration assured members that it had no intention to implement the proposed scheme immediately as the implementation of such a scheme would take many years to complete. Subject to public views during the consultation period, the Administration planned to commission a feasibility study on the scheme in 2001-2002 and the public would be consulted on its findings and recommendations in due course.

Mechanism for handling medical complaints

11. In the Consultation Document on Health Care Reform, the Administration proposed to set up a Complaint Office in DH to assist patients in lodging complaints. As DH would give up its direct health care services eventually and take on the role of an advocate for health and a regulator to ensure quality, the Administration considered it well-placed to take on the task. However, a majority of members did not support the proposal and maintained their view that an independent mechanism should be established to handle medical complaints to ensure credibility and impartiality.

12. Following strong public criticisms of the Medical Council of Hong Kong over its decision in a disciplinary enquiry involving a public doctor who had used his mobile phone to answer an incoming personal call during a surgery, the Panel held a special meeting for the Medical Council to brief members on the matter in April 2001. At the conclusion of the meeting, members agreed that a subcommittee should be set up to discuss with the Administration how to improve the mechanism for handling medical complaints. The subcommittee met with the professional, patient and other organisations concerned to listen to their views in June 2001. Representatives of the Medical Council and the Public Complaints Committee of HA also met the subcommittee to brief members on the progress of the Medical Council's reform proposals and the HA's complaints system respectively. The subcommittee would continue discussion with the Administration on the subject.

Long working hours of public hospital doctors

13. The Administration briefed the Panel in February 2001 on the progress made by HA in addressing the issue of long working hours of public hospital doctors, including the outcome of a review on the issue conducted by the Working Group on Working Hours of Doctors. Members noted that a number of common bases had been reached for tackling the problem, with the guiding principle being that patient care must come first irrespective of how doctors' hours were structured.

14. Representatives of the Hong Kong Public Doctors' Association (HKPDA) pointed out that no concrete plan had been drawn up by HA to achieve the three goals agreed by both HA and members when the matter was last discussed by the Panel in March 2000. These goals were provision of compensatory off to doctors who performed on-site on-call duties during statutory holidays and Sundays; continuous working hours of doctors should be limited to 28 hours; and doctors' on-call frequency should not be more than once in every three days. HKPDA considered that the main reason for HA's failure to achieve the goals was that an objective and explicit system for recording doctors' working hours was not in place.

15. HA explained that given the nature of the work of doctors, it was very difficult for them to log the actual number of hours they were on duty. As the nature of hospital operation required the provision of 24-hour services for patients, it was necessary to adopt work schedules extending beyond normal work hours and long working hours of doctors in training was a longstanding problem encountered by the medical profession worldwide. While some countries had issued guidelines or directives on doctors' working hours, there was concern that setting a limit on working hours per week would impact on the continuity of patient care and a doctor's training with regard to teaching time allocation and the trainee's ability to learn from clinical duties.

16. Members noted that the heavy workload of public doctors was due to the fact that 93% of health care services in Hong Kong was provided by HA. They agreed that the long term solution to the problem was to address the imbalance between the workload of the public and private sectors by enabling private hospitals to share more in the workload, as proposed in the Consultation Document on Health Care Reform. However, members were worried that if the problem of long working hours of doctors in public hospitals remained unsolved in the interim period, the quality of medical service would suffer and patients' lives at risk. They were particularly concerned that HA had failed to comply with the requirements of the Employment Ordinance to provide doctors with compensatory off for working during statutory holidays and a rest day every seven days.

17. HA assured members that it was committed to provide compensatory off for statutory holidays and a directive had been issued in this regard. At the same time, every effort would be made to ensure that doctors would be provided with appropriate rest after a stretch of excessively long working hours. To ensure that the long working hour issue would be taken forward at the hospital level, HA would incorporate five targets relating to on-call frequency, compensation for statutory holiday, excessive continuous hours of work and rest day, additional doctors and managing demand, which were aimed at tackling the issue, in HA's 2001-2002 Annual Plan. Members agreed that the

Administration should report back to the Panel on the progress made in this regard before the end of the year.

Proposed amendments to the Smoking (Public Health) Ordinance

18. In May 2001 the Administration briefed the Panel on its proposals to extend the ban on smoking in public places to protect members of the public from passive smoking and close loopholes identified in the existing legislation to bring about more effective enforcement of the Ordinance. The proposals included prohibition of smoking in all restaurants, bars, karaokes and other public indoor premises such as bathhouses and nightclubs; both indoor and outdoor areas of all kindergartens, primary and secondary schools; and indoor premises of universities and tertiary institutions as well as all indoor workplaces.

19. Members generally supported the Administration's proposals but had grave doubts about the enforcement arrangement for public indoor places such as restaurants and shopping malls. Similar to the existing arrangement, the management of the premises concerned would be the primary enforcement agency for the smoking ban, with the Police providing assistance when offenders refused to comply with the requirement. Members doubted whether the management of the premises concerned would be willing or able to fulfil their expected role, even though some assistance and training would be given to them by the new Tobacco Control Office set up under DH.

20. To help overcome the problem, some members suggested that the health inspectors of the Food and Environmental Hygiene Department should also be empowered to take action against people who violated the ban on smoking in restaurants. Members also urged the Administration to step up anti-smoking education to prevent young people from becoming smokers and to provide additional resources for setting up more smoking cessation health centres to help smokers quit smoking.

Introduction of Chinese medicine in the public health system

21. Members noted that the Administration would conduct pilot schemes in 2001-2002 for providing out-patient Chinese medicines services in the public sector. As many elderly people preferred Chinese medicine treatment, members asked the Administration to consider providing Chinese medicine services in all Government out-patient clinics as well as the elderly health centres of DH in the future.

22. Members shared the view that if Chinese medicine treatment was not provided in public hospital service, the development of Chinese medicine in the public health system would be very limited. Such a situation was also not satisfactory as Chinese medicine graduates from local universities would not be able to serve their internship in local hospitals. The Administration explained that it was its long term goal that the public health system could provide both

Chinese and western medicine treatment to patients and would report to the Panel on the progress of such development as and where necessary.

Control measures on clenbuterol food poisoning

23. In the wake of a spate of clenbuterol food poisoning cases, a special meeting was held in October 2000 for the Administration to brief members on the existing control system regarding the feeding of clenbuterol to pigs. Members noted that the Administration had increased the number of urine tests at slaughterhouses as well as the number of inspections of meat stalls and pig farms. It had also stepped up investigation of illegal slaughtering activities and action against illegal import of live pigs and pork. Members supported the Administration's proposal to introduce a new regulation under the Public Health (Animals and Birds) Ordinance to tackle the problem at source by banning the use of clenbuterol in animal feed and to empower the Government to seize food animals containing clenbuterol and other prohibited chemicals.

Other issues/items discussed

24. Other issues/items discussed by the Panel included funding arrangement for HA, rationalisation of public hospital services, development of a Public Health Information System, regulation of health claims, redevelopment and expansion of Pok Oi Hospital, oral health services for the elderly, proposed amendments to the Human Organ Transplant Ordinance and other health related ordinances and subsidiary legislation under the Chiropractors Registration Ordinance.

25. From October 2000 to June 2001, the Panel held a total of 13 meetings while the Subcommittee on improvements to the medical complaints mechanism held a total of four meetings.

Council Business Division 2
Legislative Council Secretariat
28 June 2001

Appendix I

Legislative Council

Panel on Health Services

Terms of Reference

1. To monitor and examine Government policies and issues of public concern relating to medical and health services.

2. To provide a forum for the exchange and dissemination of views on the above policy matters.

3. To receive briefings and to formulate views on any major legislative or financial proposals in respect of the above policy areas prior to their formal introduction to the Council or Finance Committee.

4. To monitor and examine, to the extent it considers necessary, the above policy matters referred to it by a member of the Panel or by the House Committee.

5. To make reports to the Council or to the House Committee as required by the Rules of Procedure.

Appendix II

Legislative Council
Panel on Health Services

Membership list

Chairman	Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP
Deputy Chairman	Dr Hon LO Wing-lok
Members	Hon Cyd HO Sau-lan Hon CHAN Yuen-han, JP Hon Bernard CHAN Dr Hon YEUNG Sum Hon Andrew CHENG Kar-foo Hon LAW Chi-kwong, JP Dr Hon TANG Siu-tong, JP Hon LI Fung-ying, JP Hon Michael MAK Kwok-fung (Total : 11 Members)
Clerk	Ms Doris CHAN
Legal Adviser	Mr LEE Yu-sung
Date	16 January 2001