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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 2001-2002 Legislative Council session. It will be tabled at the Council meeting on 3 July 2002 in accordance with Rule 77(14) of the Rules of Procedure.

The Panel

2. The Panel was formed by resolution of this 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 12 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

Medical complaints handling mechanism

5. The subcommittee formed under the Panel in April 2001 to discuss with the Administration how to improve the mechanism for handling medical complaints concluded its work at the end of January 2002. At the conclusion of discussions, most members of the subcommittee remained of the view that an independent complaint office outside the Government should be set up in response to the strong public call for such an office to provide a one-stop service for handling patients' complaints.

6. The Administration explained that quite a number of questions must be addressed in relation to setting up such an office. These questions included : how independent it should be; how the scope of its functions and powers should be defined; and what its relationship should be with the existing complaint channels. The Administration also expressed concern that such an office might duplicate the regulatory functions of the Department of Health (DH), add confusion to the already complex existing system, and erode the autonomy of the health care professions. In addition, the Administration pointed out that there would be serious resource implications if the office was going to employ various categories of health care professionals to support its work.

7. In the Consultation Document on Health Care Reform, the Administration had proposed to set up a Complaints Office within DH to handle complaints relating to patient care. However, the majority of members of the subcommittee did not support the proposal as they considered that it was essentially a government office and therefore lacking in independence and impartiality. In addition, nearly all of the organisations that appeared before the subcommittee did not favour the proposal and instead, expressed their support for an independent complaint office.

8. Following a review of its structure, composition, and functions, the Medical Council of Hong Kong (HKMC) submitted its recommendations to the Administration in December 2001. In relation to the complaint handling mechanism , HKMC proposed to improve its existing procedures by setting up a Complaint Receiving Division to assist complainants to file their complaints and mediate between doctors and complainants in cases not relating to professional conduct, health or competence. HKMC also proposed to increase the number of lay members in the Preliminary Investigation Committee and to set up a Disciplinary Committee, with a person with a judiciary background as the chairperson, to conduct inquiries.

9. The Administration believed that with the proper implementation of the reform measures of HKMC and improvement measures to be adopted by other organisations concerned with medical complaints, the majority of the problems of the existing system, particularly those relating to complaints against doctors, could be solved. The Administration therefore did not see the need to add an additional complaint channel which would duplicate and complicate the existing system.

10. When the Administration presented its views on the reform recommendations of HKMC and the establishment of an independent complaint office at the Panel meeting in February 2002, members refuted the Administration's arguments for not setting up an independent complaint office. Some members pointed out that the Administration's stance was a regression

and considered that the Administration's earlier proposal of setting up a Complaints Office within DH was preferable to relying on the reform measures of HKMC.

11. At the conclusion of the discussion, the Panel passed a motion urging the Administration to expeditiously set up a Complaints Office within DH to receive medical complaints, conduct preliminary investigations, make referrals and conduct mediation; and to examine at an appropriate time how to gradually move such Office towards independence. The Administration undertook to consider the proposal and revert to the Panel.

Community psychiatric services of the Hospital Authority (HA)

12. As the provision of community psychiatric services was an issue of major concern to the Panel, the Administration briefed the Panel on HA's new initiatives to enhance its community psychiatric services. Members noted that in recent years, the international trend in the provision of care for patients with mental illness was to move away from institutionalised care and to focus on the development of community psychiatric services. In line with the international trend, HA had enhanced the provision of community-based psychiatric services, which were currently mainly provided by multi-disciplinary Community Psychiatric Teams, Psychogeriatric Teams and Community Psychiatric Nurses.

13. As part of its new initiatives undertaken in recent years to enhance the provision of community-based psychiatric services, HA had increased the number of its Community Psychiatric Teams from five to eight and the number of Community Psychiatric Nurses from 85 to 90 in 2001-02. It had also recruited 101 community outreach workers to visit and initiate contacts with discharged mental patients. In addition, HA had implemented, in collaboration with the primary care providers, education and welfare agencies, a pilot programme for early detection and treatment of young people with psychotic illness as severe mental illness, such as schizophrenia and severe mood disorders.

14. HA would implement a five-year pilot project, known as EXITERS (Extended-care patients intensive treatment, early diversion and rehabilitation stepping-stone), in 2002-03 to divert a group of "extended care" patients, who would otherwise be placed in large residential facilities, to home-like environment for intensive rehabilitation and treatment. "Extended care" patients who had the potential to live independently in the community but required additional medical attention before discharge would be selected to join the pilot project. Arrangement would be made for these patients to return to the community after the one-year programme, with appropriate support to be provided by Community Psychiatric Nurses. Starting with a patient intake of 100 in 2002-03, HA planned to increase the intake to 125 in 2003-04 and 150

per year thereafter and a critical evaluation would be conducted in 2006 to assess its effectiveness.

15. While members agreed that the various initiatives undertaken by HA to enhance the provision of community psychiatric services were moving in the right direction, they were concerned that these initiatives were far from adequate to meet the needs of patients. In particular, members pointed to the shortage of places in halfway houses and long stay care homes and the grossly inadequate aftercare services for discharged mental patients to help them integrate into the community.

16. The Administration explained that due to resource constraints, enhancement of community psychiatric services could only be taken forward in a progressive manner. In response to members' concern about the existing inadequate level of rehabilitation services for discharged mental patients, the Administration pointed out that SWD had allocated $30 million in 2001-02 to enhance such services. Co-ordination between HA and the government departments concerned would be strengthened to bring about more focused efforts in helping patients and their families/carers. To shorten the queue for residential places, the number of halfway houses and long stay home places would increase by 160 and 400 respectively with the coming into operation of two rehabilitation complexes in 2004-05. As requested by members, the Administration would provide the Panel with a paper setting out in detail how it intended to address the issue of rehabilitation of discharged mental patients in the near future.

Financial situation of the Hospital Authority

17. Following press reports of HA's budget deficits in 2002-03, the Administration briefed members on the financial situation of HA in 2002-03 and the measures HA would implement to address it short-term budget deficit. Members noted that Government's gross recurrent subvention to HA in 2002-03 totalled $30,882 million while HA's projected expenditure amounted to $31,327 million, resulting in a shortfall of $445 million in operating cost. This amount, together with a projected shortfall of $137 million in non-medical income, resulted in an estimated budget deficit of $582 million in 2002-03, representing about 1.9% of the gross recurrent subvention for that year.

18. The Administration explained that the budget deficit of HA was technical in nature and HA planned to cover the projected deficit for 2002-03 by its own reserve to ensure that the existing level and quality of public medical services would not be affected. HA would continue to improve its efficiency and cost effectiveness as a health care provider to ensure its long-term sustainability in delivering medical services within the available resources.

19. As productivity enhancement initiatives formed an important part of the measures to help address the short-term deficit, members expressed concern about the impact of the implementation of such initiatives on staff. HA pointed out although such initiatives had resulted in staff taking up more tasks, their additional workload had at the same time been off-set by the implementation of the new cluster-based management which enabled work to be delivered in a more efficient manner.

20. As regards demand management, members noted that apart from reengineering the provision of health care services in HA to develop the more cost-effective ambulatory and community-based services, HA would continue to strengthen the co-operation and interface with the private sector. HA would encourage public/private collaboration through the formulation of referral protocols, development of collaborative models of service provision and skills training programmes to facilitate the upgrading of skills of private practitioners as well as facilitating shared-care by sharing patient information with private practitioners.

Working hours of public hospital doctors

21. In January 2002 the Administration briefed the Panel on the progress made by HA in addressing the issue of long working hours of public hospital doctors since the Panel last discussed the issue in February 2001. Members noted that HA had pledged in its 2001-02 Annual Plan to reduce frontline doctors' work hours by recruiting more doctors to relieve the work of busy departments, facilitating compensation for statutory holidays, better arrangement of on-call duties and provision of rest periods after long hours of work.

22. As part of its measures to address the problem, HA recruited 312 doctors in 2000-01 and another 303 doctors in 2001-02 to alleviate the workload of doctors. Monitoring mechanisms had been set up to ensure that compensatory off for statutory holiday would be provided in accordance with the Employment Ordinance and that doctor's on-call frequency was not more than once in every three days. As regards rest days, individual hospitals had made continuous efforts to enhance the communication process between supervisers and frontline doctors with a view to coming up with mutually agreed arrangements on the provision of weekly rest days.

23. Members were concerned that HA still failed to fully comply with the Employment Ordinance by providing doctors with one rest day every seven days. HA pointed out that as result of the provision of additional doctors in the past two years, 60% of the 90 departments audited could grant one rest day every week to medical officers/residents and a further 32% could grant some form of rest days. The situation for interns had also improved , with 20% of the

44 departments granting one rest day every week and a further 34% granting some form of rest days. The reason why granting one rest day every week for all doctors could not be fully achieved thus far was because to do so would entail a significant increase in the number of doctors within a short period, which was not possible, and therefore a gradual approach had to be adopted. Nevertheless, it was an area on which HA was now focusing and it was the long-term goal of both the Administration and HA that doctors would be granted one rest day every week.

24. Several members shared the view that HA was violating the law in failing to grant all doctors one rest day every week and urged that this be rectified expeditiously. Although HA was of the view that the provision of one rest day per week did not have to be applied strictly if the employees agreed to some other form of rest day, it undertook to seek legal advice on the issue. Members agreed that working hours of public hospital doctors should be made a standing issue for discussion by the Panel on a yearly basis. Members asked for the full results of the recent audit survey on doctors' working hours to be provided for their reference.

25. In response to the Panel's request, the Administration provided the report on the Audit Survey of Doctors' working Hours compiled by HA and a breakdown of new doctors recruited in 2000-01 and 2001-02 by nature of deployment for members' information in May 2002. The Administration pointed out in its response that HA would not provide its legal advice on the interpretation of the Employment Ordinance as legal proceedings were in train. About 160 public hospital doctors had filed claims to the Labour Tribunal against HA in connection with the granting of rest days and statutory holidays in the past six years and the case had been transferred to the High Court.

Regulation of medical devices

26. In the light of the proposal in the Consultation Document on Health Care Reform to provide regulation of medical equipment with a view to ensuring that patients would receive quality service, the Administration briefed the Panel on the details of a preliminary proposal on the regulation of medical devices. Members noted that the Administration would conduct a consultation exercise to seek the opinions of the trade and operators of medical devices prior to the implementation of the regulation system.

27. Members expressed concern that the definition of medical devices, including that of Chinese medical devices, should be clear and the classification of their risk levels objective. In addition, the Administration should conduct an impact study of the proposed regulation on the workforce and consider setting up an appeal system in case of disputes arising from the regulatory system. Members were also concerned that non-mandatory requirements such as recall

of defective products by manufacturers or their representatives and report of adverse incidents by non-healthcare professionals might not be effective. Members noted that the Administration would work out a detailed proposal after the consultation exercise and revert to the panel for further discussions.

Other matters discussed

28. Other subject matters discussed by the Panel included the preventive programmes and the redefined roles of DH and reorganisation of its Central Health Education Unit, remodelling of Tang Shiu Kin Hospital into an Ambulatory Care Centre, redevelopment and expansion of Pok Oi Hospital, establishment of a radiotherapy centre and redevelopment of the Accident and Emergency Department at Princess Margaret Hospital.

29. From October 2000 to June 2001, the Panel held a total of eight meetings and made a visit to the Chinese University of Hong Kong Chinese Medicine Clinical Research and Services Centre at Kwong Wah Hospital. The Subcommittee on improvements to the medical complaints mechanism held a total of three meetings during the period.

Council Business Division 2
Legislative Council Secretariat
2 July 2002

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 Kwok-keung
	Hon CHAN Yuen-han, JP
	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 Tommy CHEUNG Yu-yan, JP
	Hon Michael MAK Kwok-fung
	(Total : 12 Members)
Clerk	Ms Doris CHAN
Legal Adviser	Mr LEE Yu-sung
Date	12 October 2001