# *立法會*
# *Legislative Council*

LC Paper No. CB(2)564/02-03
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

**Panel on Health Services**

**Minutes of meeting**
**held on Monday, 11 November 2002 at 8:30 am**
**in Conference Room A of the Legislative Council Building**

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| **Members Present** | : | Dr Hon LO Wing-lok (Chairman)<br>Hon Michael MAK Kwok-fung (Deputy Chairman)<br>Hon Cyd HO Sau-lan<br>Hon Albert HO Chun-yan<br>Hon CHAN Yuen-han, JP<br>Hon Andrew CHENG Kar-foo<br>Dr Hon LAW Chi-kwong, JP<br>Dr Hon TANG Siu-tong, JP |
| **Members Absent** | : | Hon CHAN Kwok-keung<br>Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP<br>Dr Hon YEUNG Sum<br>Hon LI Fung-ying, JP |
| **Members Attending** | : | Hon LEE Cheuk-yan<br>Hon Fred LI Wah-ming, JP |
| **Public Officers Attending** | : | All items<br><br>Mr Thomas YIU, JP<br>Deputy Secretary for Health, Welfare and Food (Health) |

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Item III

Dr William HO, JP
Chief Executive, Hospital Authority

Items III and V

Dr W M KO, JP
Director (Professional Services & Public Affairs), Hospital Authority

Item V

Miss Joanna CHOI
Principal Assistant Secretary for Health, Welfare and Food (Health) 2

Dr Beatrice CHENG
Executive Manager (Professional Services)

Miss Kathy CHAN
Assistant Secretary for Health, Welfare and Food (Health) 5

**Clerk in Attendance** : Ms Doris CHAN
Chief Assistant Secretary (2) 4

**Staff in Attendance** : Miss Mary SO
Senior Assistant Secretary (2) 8

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**I. Confirmation of minutes**
(LC Paper No. CB(2)124/02-03)

The minutes of meeting held on 10 October 2002 were confirmed.

**II. Items for discussion at the next meeting**
(LC Paper Nos. CB(2)280/02-03(01) to (03))

2. Members proposed to discuss the following items at the next meeting scheduled for 9 December 2002 -

(a) Working Groups on Public/Private Interface - Progress Report;

(b) Chinese medicine outpatient services; and

(c) Redevelopment of staff quarters for the establishment of a rehabilitation block at Tuen Mun Hospital.

3. Deputy Secretary for Health, Welfare and Food (DSHWF) said that the Administration would not be in a position to discuss Chinese medicine outpatient services in December 2002, but would propose a replacement item after the meeting.

4. Referring to the letter from the Association of Hong Kong Nursing Staff requesting this Panel and the Panel on Security to hold a joint meeting to discuss medical care services to inmates of Siu Lam Psychiatric Centre (LC Paper No. CB(2) 280/02-03 (03)), the Chairman said that the Panel on Security had already held a special meeting on 5 November 2002 to discuss the issue and would follow up the matter in January 2003. Members agreed that since they would be invited to join the discussion of the matter, there was no need for a joint meeting.

**III. Follow-up discussion on the restructuring of fees and charges for public health care services - the fee waiver system**

(Legislative Council Brief on the restructuring of fees and charges for public health care services - Ref : HWF CR/13/2/3921/96(01) Pt.7)

5. Members noted the Administration's response to an enquiry made by Ms Emily LAU at the special meeting held on 5 November 2002 concerning the fee income written off by the Hospital Authority (HA) in the past three years, which was tabled at the meeting.

6. At the invitation of the Chairman, DSHWF said that, as mentioned at the special meeting held on 5 November 2002, the existing fee waiver system would be enhanced to become a medical fee assistance scheme. The new scheme aimed to ensure that no one would be denied adequate medical care due to lack of means after the revamp of the fees structure and to ensure that the fee revision would not impact disproportionately on low income groups. Under this enhanced scheme, a set of objective and transparent criteria would be developed to assess a patient's eligibility for partial or full exemption of public medical fees. In determining a patient's eligibility for exemption, Medical Social Workers (MSWs) would take into account a patient's financial condition in relation to the Monthly Median Domestic Household Income, clinical condition in terms of frequency of use of the

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services and age. Other factors such as any relationship problems between the patient and his/her relatives, or other special expenses specific to the patient's family situation which might render it difficult for the patient to pay the medical expenses would also be considered by MSWs. On implementation of the enhanced system, the initial thinking was to issue a fee reduction/waiver card with a specified validity period to the eligible patients.

7. DSHWF further said that the imposition of a charge of $100 per attendance for accident and emergency (A&E) service at public hospitals on 29 November 2002 would not impose a heavy financial burden on the general public. This was because firstly not everyone would need to use A&E service, which was designed for patients in emergency and life-threatening conditions. Secondly, recipients of Comprehensive Social Security Assistance (CSSA) would continue to be exempted from the A&E charge. Thirdly, patients who had difficulty to pay the A&E fee could seek financial assistance from MSWs under the existing fee waiver system. And fourthly, patients who might use more A&E service, namely, chronic patients and the elderly with low income, had already been granted exemption from paying public medical fees either partially or in full and such exemption would also cover the A&E fee.

8. DSHWF added that the occurrence of a situation of a non-CSSA elderly in emergency conditions refraining from using A&E service, as mentioned by some members at the last meeting held on 5 November 2002, should be rare. This was because, as explained in paragraph 7 above, many elderly patients not on public assistance had already been granted partial or full exemption of public medical fees, and such exemption would also apply to the new A&E fee. Nevertheless, to avoid the aforesaid situation from occurring, HA staff would step up efforts to apprise elderly patients of the existing fee waiver system and that under no circumstances would patients be denied treatment because of their inability to pay the A&E fee. The Administration would also enlist the assistance of non-governmental organisations, operators of residential homes for the elderly, etc. to convey the same message to their elderly clients.

9. Chief Executive, HA briefed members on the procedures which would be adopted by HA for the collection of A&E fee. Upon registration for treatment at the A&E Department of a public hospital, patients or their family members would be asked to pay the A&E fee. If the patients or their family members were unable to settle the payment immediately, a debit note would be issued to them for payment later. A leaflet introducing the fee waiver system for non-CSSA recipients would also be given to the patients or their family members upon the issuance of the debit note if they indicated that they had difficulty in paying the A&E fee. If a patient failed to pay the A&E fee afterwards and did not approach a MSW to seek assistance to settle the fee, HA would first telephone the person

concerned or his or her family members to remind them to settle the outstanding payment. If the person concerned failed to settle the outstanding payment within two weeks thereafter, a fee collection letter would be issued. And if the person concerned still failed to respond to the collection letter within three weeks, a registered letter would be issued. All these procedures were in line with the existing procedures for other hospital charges.

10. Dr LAW Chi-kwong opined that no matter how much efforts were made to apprise non-CSSA elderly of the fee waiver system, some of them would still refrain from using A&E service because they did not want to undergo a means test and/or to disclose to MSWs their relationship problems with their relatives which had rendered it difficult for them to pay the A&E fee. To lift such psychological burden from the elderly, Dr LAW was of the view that patients aged 65 and above should be exempted from paying the A&E fee. This was not unreasonable, as presently over 60% of the elderly aged between 65 and 69 were recipients of Normal Old Age Allowance (NOAA) and one needed to pass an income and assets test to receive NOAA.

11. DSHWF disagreed with Dr LAW's suggestion, which went against the principle that assistance should only be targetted at those in need and not those who could afford. Chief Executive, HA supplemented that the existing fee waiver system had all along been operating smoothly, and he failed to see how it would be otherwise after the introduction of A&E charge. Chief Executive, HA further said that the application procedures for exemption of public medical fees were uncomplicated, and applicants did not have to wait long to meet with MSWs to discuss their applications.

12. Dr LAW Chi-kwong further said that the introduction of A&E charge would put many elderly patients not on CSSA in an unfair situation. At present, these elderly patients could go to the A&E Department of a public hospital to receive treatment, which was free of charge, if they could not get a consultation disc at the Government general out-patient (GOP) clinic. In future, not only would they have to pay $100 per A&E attendance, they would also need to wait for a longer time than at GOP clinics.

13. Chief Executive, HA responded that the existing GOP service was adequate to cope with patients' demand, as evidenced by the fact that the overall utilisation of GOP clinics was not full. HA would review the GOP service after the introduction of A&E charge had come into operation. Chief Executive, HA hoped that with the introduction of A&E charge, inappropriate use of A&E service could be reduced, given that the average unit cost of A&E service was higher than of GOP service, i.e. $570 versus $226.

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14. Dr LAW Chi-kwong remarked that the fact that the overall GOP service had spare capacity did not mean that each and every GOP clinic had spare capacity. To his knowledge, some GOP clinics, particularly those located near residential areas, often had to turn away patients. In the light of this, Dr LAW asked whether consideration could be given to operating the GOP clinics on a 24-hour basis and/or arranging more doctors to treat patients during peak periods so as to avoid patients not in emergency conditions "misusing" the A&E service.

15. Chief Executive, HA responded that although some GOP clinics did turn away patients, this was not an everyday occurrence and patients who failed to see doctors on a particular day would usually succeed the following day. Chief Executive, HA further said that there was no need to extend the operating hours of GOP clinics, as evening GOP clinics presently had spare capacity. Moreover, more and more private providers were operating evening OPC service and at a reasonable fee.

16. Dr LAW Chi-kwong suggested that members of the public should be allowed to apply ahead for reduction or waiver of A&E fee, so that they could be certain of their financial commitment in the event they needed to use A&E service. Ms Cyd HO and Mr Andrew CHENG concurred with Dr LAW, and asked whether HA would consider doing so between now and 29 November 2002.

17. Chief Executive, HA responded that the suggestion in paragraph 16 above would not be workable, as there was insufficient basis for MSW to assess an applicant's eligibility for financial assistance if the applicant had never used HA service. However, existing HA patients who had never applied for financial assistance could apply for a reduction or waiver of A&E fee now if they so wished.

18. Both Ms Cyd HO and Mr Fred LI expressed dissatisfaction that the Administration had failed to provide any information on the enhanced fee waiver system to the Panel since the last meeting, but had on the other hand disclosed to the media bits and pieces of the enhanced system. In response, DSHWF said that

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the Administration would consult members on the enhanced system after the relevant details had been drawn up.

19. Mr Andrew CHENG and Miss CHAN Yuen-han requested the Administration to postpone introducing the new A&E charge to 1 April 2003 when the enhanced fee waiver system would come into operation. DSHWF responded that it was not necessary to do so, as the existing fee waiver system was adequate to help patients who could not afford the A&E charge. This was because as explained earlier at the meeting, $100 per A&E attendance should be generally affordable given that not everyone needed to use A&E service and few

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would need to use it. As to those who might use more A&E service, namely, chronic patients and the elderly, most of those with low income had already been granted partial or full exemption of public medical fees and such exemption would also apply to the new A&E fee. Moreover, CSSA recipients would continue to be exempted from paying the A&E fee. DSHWF further explained that the proposed enhanced fee waiver system sought to establish a more objective and transparent criteria for assessing a patient's eligibility to ensure the successful implementation of the revamping of fees structure and to ensure that the fee revision would not impact disproportionately on low income groups.

20. Mr Fred LI asked the following questions -

(a) Whether HA would consider changing the work pattern of MSWs to 24-hour basis to tie in with the introduction of A&E charge;

(b) Whether one of the criteria for assessing a patient's eligibility for partial or full exemption of public medical fees would be based on whether 10% or more of his or her household income was spent on his or her medical care, as reported in the newspapers;

(c) Whether the estimated additional annual revenue of $350 million generated from the revised fees and charges had already taken out the amount of fees which would be reduced and waived under the enhanced fee waiver system; and

(d) Whether the additional revenue generated from the revised fees and charges would be kept by HA or go into the public coffer.

21. Chief Executive, HA responded that there was no need to provide MSW service on a 24-hour basis to tie in with the introduction of A&E charge, as patients would not be required to settle the A&E fee immediately. Moreover, the number of patients who would need to apply for reduction or waiver of the A&E fee should not be significant for the reasons given in paragraph 19 above.

22. In reply to Mr LI's second question, DSHWF clarified that exempting patients who spent 10% or more of their household income on medical care was one of the possible criteria being considered for the enhanced fee waiver system. DSHWF added that at present only the top 2% of the most frequent users of HA services spent 10% or more of their household income on medical care, whereas the rest only spent between 1% to 2% of their household income on the same.

23. As regards Mr LI's third question, DSHWF confirmed that the estimated additional annual revenue of $350 million generated from revised fees and charges

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had already taken out the amount of fees which would be reduced and waived under the enhanced fee waiver system. DSHWF pointed out that about 30% of HA patients were presently exempted from paying medical fees. Amongst them, 60% were CSSA recipients and the remaining 40% were successful applicants of the fee waiver system. However, it was envisaged that the percentage of patients who would be exempted from paying medical fees under the enhanced fee waiver system would be slightly higher.

24. As to Mr LI's last question, DSHWF said that the Administration had not come to a decision as to whether the additional revenue generated from the fee revision could be kept by HA; and if so, how much. In considering the matter, due regard would be given to HA's funding arrangement, service needs and the financial situation of Government.

25. Mr Michael MAK declared that he was an employee of HA. Mr MAK expressed support for the introduction of A&E charge, and urged the Administration to enhance public education on the proper use of A&E service. Mr MAK further said that merely relying on imposing a fee for using A&E service would not be enough to discourage misuse of the service. In his view, discouraging misuse of A&E service must be supplemented by the strengthening of GOP service, say, by providing a 24-hour service, and raising public awareness of the proper use of A&E service.

26. Chief Executive, HA responded that apart from the measures mentioned in paragraph in 8 above, the HA community geriatric assessment team could also help out during its visit to the residential homes should elderly residents wish to apply for assistance under the fee waiver system, if they anticipated difficulty in paying the A&E fee. Chief Executive, HA reiterated that it was not necessary to extend the service hours of GOP clinics for the reasons given in paragraph 15 above. He added that HA intended to publicise to patients at each GOP clinic the addresses and service hours of private outpatient clinics in the neighbourhood. DSHWF supplemented that the efficiency of the GOP service would be enhanced after the transfer of the remaining GOP clinics from the Department of Health (DH) to HA in the second half of 2003 when the practice of the family medicine would be adopted throughout. On the question of raising public awareness of the proper use of A&E service, Chief Executive, HA said that each patient and his or her family members were given a leaflet on such when they visited the A&E Department of a public hospital. DSHWF also said that DH would continue to step up work in this regard.

27. At the request of Mr Michael MAK, the Administration undertook to provide information on the percentage of unsuccessful applications for seeking reduction or wavier of public medical fee in the past three years after the meeting.

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28. Dr TANG Siu-tong said that it was not the right time to introduce the A&E charge, having regard to the current economic downturn. Dr TANG then asked the following questions -

(a) What was the administrative cost for implementing the A&E charge;

(b) Whether HA would refuse to give treatment to a patient who had failed to settle the outstanding fees; and

(c) Whether there was any mechanism for unsuccessful applicants to appeal against the decisions of MSWs under the existing fee waiver system.

29. Chief Executive, HA responded that the administrative cost for implementing the A&E charge should be negligible, having regard to the procedures outlined in paragraph 9 above and the anticipation that the fee income which would be written off by HA after the introduction of the A&E charge should remain unchanged at around 2% as in the past years. Regarding Dr TANG's second question, Chief Executive, HA assured members that treatment would be given to patients even though they had outstanding public medical fees. As to Dr TANG's last question, Chief Executive, HA said that he was not aware of any incident of appeal against the decisions of MSWs. Nevertheless, he agreed to give further thoughts on the mechanism in the enhanced fee waiver system.

30. Miss CHAN Yuen-han hoped that the Administration would not assume that Members had given the green light to the Health Protection Accounts (HPA) scheme simply because the scheme was mentioned in the Legislative Council Brief on the restructuring of fees and charges for public health care services presented to members at the last meeting held on 5 November 2002 and Members had no raised any query on it so far.

31. DSHWF responded that the Administration was currently studying the feasibility of implementing an HPS scheme in Hong Kong, and should be in a position to report back to the Panel in the second half of 2003 on the way forward. DHSWF clarified that the idea of implementing an HPS scheme was not to change the existing heavily-subsidised public health care system into a user-pay one, but was merely intended as one of the supplementary sources of funding to ensure the long-term financial sustainability of the public health care system.

32. Dr LAW Chi-kwong urged the Administration to re-consider changing the service hours of GOP clinics to 24 hours and assigning more doctors to see

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patients during peak periods. To ensure proper use of A&E service, Dr LAW suggested that patients considered not to be in critical conditions be referred from the A&E Department of a public hospital to a GOP clinic nearby if the latter had spare capacity. As the validity period for fee exemption was three months at present, Dr LAW was of the view that patients whose validity period for fee exemption had expired and who had been granted exemption from paying public medical fees within one year should be exempted from paying the A&E fee. Similarly, older persons aged 65 and above and who had previously been granted fee exemption within one year should continue to be granted fee exemption for using A&E service. Chief Executive, HA agreed to give further thoughts to Dr LAW's last two suggestions.

## IV. Regulation of health claims
(LC Paper No. CB(2)280/02-03(04))

33. As the discussion of agenda item III had used up the scheduled time for item IV, the Chairman suggested and members agreed to defer the discussion of this item to the next meeting.

## V. Patients' Choice Item Pilot Scheme
(LC Paper No. CB(2)280/02-03(05))

34. Director (Professional Services & Public Affairs), HA (Director, HA) took members through the Administration's paper on the Patients' Choice Item (PCI) Pilot Scheme implemented by the New Territories East (NTE) Cluster of HA.

35. Mr Michael MAK enquired whether other HA Clusters would be providing drugs on the list of "non-essential" drugs compiled by NTE Cluster. Mr MAK said that it would be very unfair to the patients of NTE Cluster if the answer was in the negative as whether a patient would need to pay for his or her drugs would depend entirely on the decisions of his or her doctors.

36. Director, HA responded that it was not uncommon for different hospitals in overseas countries to have different lists of "essential" and "non-essential" drugs. However, in light of the benefits of having standardised lists of "essential" and "non-essential" drugs and given the close proximity of public hospitals in Hong Kong, HA was presently working on developing such lists for use by all public hospitals.

37. The Chairman said that the Administration should consult members if it decided to extend the PCI Scheme to other HA Clusters. Director, HA agreed

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and added that the standardised lists of "essential" and "non-essential" drugs would be made known once they were developed.

38. Mr Michael MAK enquired whether the NTE Cluster had received complaints from patients arising from the implementation of the PCI Pilot Scheme. Director, HA responded that this was inevitable, given that news on "break-through" drugs and new alternatives over existing therapy could now be easily accessed on the Internet and elsewhere. Nevertheless, doctors would endeavour to explain to the patients concerned the reasons why a certain drug was classified as "non-essential" item.

39. Mr Albert HO said that to replace the existing drug utilisation guidelines used for classifying drugs into "essential" and "non-essential" items with standardised lists of "essential" and "non-essential" drugs could not stamp out criticisms about the arbitrariness of the PCI Scheme. Mr HO asked how HA would intend to classify a certain drug as an "essential" item or otherwise if the drug had better efficacy but was of disproportionately higher cost when compared with available alternatives.

40. Director, HA conceded that it was very difficult to strike a right balance between allowing doctors the flexibility to prescribe drugs for patients according to their clinical conditions and developing standardised lists of "essential" and "non-essential" drugs which aimed at targetting public resources to be used on patients in need. Director, HA further said that as a general principle, if a drug had marginal efficacy but was of disproportionately higher cost when compared with available alternatives, patients would be informed to purchase the drug themselves. On the other hand, if a drug had marked efficacy but was slightly more expensive than available "essential" drugs, HA would tend to standardise this drug as an "essential" item. However, such a demarcation could not be so easily made if the elements of risk to patients and ethics were also taken into consideration. In the light of this, the HA Ethics Committee was presently developing a set of fundamental principles aiming to balance the interests of patients, the autonomy of doctors, the principle that public resources should be used on patients in need and public expectations.

41. Referring to paragraph 3(b) of the Administration's paper which mentioned that one of the three principles adopted by the NTE Cluster in classifying drugs as "non-essential" was drugs with comparatively fewer side effects, marginally better efficacy but were of disproportionately higher cost when compared with available alternatives, Dr LAW Chi-kwong said that the words "fewer side effects" should be deleted as efficacy already included side effects on patients. Dr LAW was also of the view that the public should be consulted after the HA Ethics Committee had drawn up a set of principles on the classification of drugs as "essential" and

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"non-essential".

42. Director, HA agreed with Dr LAW's first suggestion in paragraph 41 above. Director, HA, however, expressed reservation about Dr LAW's second suggestion, as the general public would not have the requisite knowledge and experience to make constructive comments on the principles on the classification of drugs as "essential" and "non-essential", which involved the balancing of various conflicting interests.

## VI. Any other business

43. There being no other business, the meeting ended at 10:45 am.

Council Business Division 2
Legislative Council Secretariat
5 December 2002