立法會
Legislative Council

LC Paper No. CB(2)831/02-03
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 9 December 2002 at 8:30 am
in Conference Room A of the Legislative Council Building

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

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

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Miss Angela LUK
Principal Assistant Secretary for Health, Welfare and Food (Health) 1

Dr P Y LAM, JP
Deputy Director of Health

Dr Thomas CHUNG
Principal Medical and Health Officer, Department of Health

Item V

Mr Eddie POON
Principal Assistant Secretary for Health, Welfare and Food (Health) 3

Items V and VI

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

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

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

I. Confirmation of minutes

(LC Paper Nos. CB(2)393/02-03, CB(2)491/02-03 and CB(2)564/02-03)

The minutes of the joint meeting with the Panel on Food Safety and Environmental Hygiene held on 22 October 2002, the minutes of the special meeting held on 25 October 2002 and the minutes of meeting held on 11 November 2002 were confirmed.

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II. Information paper issued since the last meeting
(LC Paper No. CB(2)537/02-03(01))

2. Members noted the letter dated 19 November 2002 from the Chiropractic Doctors' Association of Hong Kong Limited regarding the code of practice drafted by the Chiropractors Council and raised no query.

III. Items for discussion at the next meeting
(LC Paper Nos. CB(2)554/02-03(01) and (02))

3. Members proposed to discuss the following items at the next meeting scheduled for 13 January 2003 -

(a) Chinese medicine outpatient services;

(b) Proposed amendments to the Smoking (Public Health) Ordinance; and

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

4. Deputy Secretary for Health, Welfare and Food (DSHWF) said that the Administration might not be in a position to discuss the proposed amendments to the Smoking (Public Health) Ordinance in January 2003. He would propose a replacement item after the meeting if that was the case.

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

5. At the invitation of the Chairman, Deputy Director of Health (DDH) took members through the Administration's paper which set out the Administration's detailed proposal on the regulation of health claims.

6. Dr LAW Chi-kwong enquired about the scope of the Administration's proposal, as it was unclear whether orally consumed products with claim that they could strengthen the body, such as vitamin C, would be prohibited.

7. DDH responded that orally consumed products with claim that they could strengthen the body would not be prohibited, as such a claim was a general one. At present, specific claims relating to prevention or treatment of diseases were

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considered pharmaceutical products and were required to be registered under the Pharmacy and Poisons Ordinance (PPO)(Cap. 138) or, where appropriate, the Chinese Medicines Ordinance (CMO) (Cap. 549) when the relevant provisions of the latter Ordinance became effective. Furthermore, the Undesirable Medical Advertisements Ordinance (UMAO) (Cap. 231) prohibited advertisements claiming that a product had curative or preventive effects on any of the diseases listed in a schedule to the Ordinance.

8. DDH further said that the proposal on the regulation of health claims was aimed at prohibiting claims which had high public health risk, namely, claims relating to body functions such as regulation of blood pressure and regulation of blood glucose of diabetic patients etc. The purpose of the prohibition was to prevent improper self-medication by members of the public, thereby causing harm as a result of either the improper self-medication itself, or the delay in seeking proper treatment. The proposal, however, was open on whether exaggerated or misleading health-related claims which had relatively lower public health risk, such as weight reduction, detoxification, etc., should be regulated. Regulation of these claims required the consensus in the community. In regulating these claims, a balance would need to be struck between protection of public health and freedom of choice of consumers.

9. Dr LAW Chi-kwong expressed concern that the proposed regulation of health claims would be difficult to enforce. For instance, it was questionable whether a person who published, or caused to publish, any advertisement that a slimming product could make users more beautiful should be prosecuted.

10. DDH agreed that enforcement of the proposed regulation of health claims would be difficult at times, such as in the case highlighted by Dr LAW in paragraph 9 above. It would be ideal if all health food products were required to undergo testing to substantiate their claims before they could be offered for sale in Hong Kong. The Administration would explore the adoption of such an arrangement after the implementation of regulation of health claims. DDH, however, pointed out that not all health claims could be proved by scientific means. Nevertheless, such a pre-market approval mechanism could ensure that all health food products were assessed for their safety for human consumption.

11. In response to the Chairman's enquiry, DDH confirmed that vitamin C was required to be registered as pharmaceutical product under the PPO.

12. Ms LI Fung-ying expressed support for the regulation of health claims, but had concern as to whether the list of prohibited claims to be included in a new schedule to the UMAO was exhaustive enough to prevent health food products from making irresponsible claims. In view of her concern, Ms LI enquired how

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the list of prohibited claims would be compiled.

13. DDH responded that the list of prohibited claims to be included in the UMAO as a new schedule would be by categories to avoid grey areas as far as possible. DDH pointed out that under the proposed regulation, the Director of Health should have the power to amend the list of prohibited claims and extend its coverage to cover other products and services as necessary having regard to latest development and for the protection of public health.

14. Ms Cyd HO said that similar to drugs, all food products, including health food products, should be regulated to better protect public health. To this end, Ms HO enquired about the measures which would be taken by the Administration to address such. Ms HO further enquired whether misleading or exaggerated claims made by individuals, such as those made by celebrities in advertisements for slimming products, would be prohibited; and if so; whether the individuals concerned would be held liable for committing an offence under the UMAO. Mr Michael MAK and Dr TANG Siu-tong raised similar questions.

15. DDH responded that all general food products were presently regulated by the Public Health and Municipal Services Ordinance (PHMSO) (Cap. 132) to ensure that they were fit for human consumption. As regards food products generally described as "health food" which were presently not regulated, over 80% of them contained Chinese medicines would come under regulation when the subsidiary legislation on the registration of Chinese medicines would come into operation by phases next year. The remaining 20% of the health food products would be regulated by the UMAO following the inclusion of a list of prohibited claims in the Ordinance. To tighten control on food products claiming health benefits, the Administration would next consider requiring these products to first register with the Department of Health (DH) and undergo testing to substantiate their claims before they could be offered for sale in Hong Kong.

16. DDH further said that he would seek legal advice on whether misleading or exaggerated claims made by celebrities in advertisements for slimming products would be prohibited; and if so; whether the individuals concerned would be held liable. The Administration would also take into consideration the said issue when drafting the legislation to give effect to the proposal on regulation of health claims.

17. Responding to Ms HO's further enquiry on the implementation timetable for the regulation of health food products, DDH said that the Administration planned to submit the legislative proposal to effect the proposals set out in paragraph 6 of the Administration's paper within the current legislative session. As regards the regulation of health food products containing Chinese medicines,

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DDH said that this would take about two to three years to complete in view of the large number of proprietary Chinese medicines in the market. No timetable, however, had been set for the implementation of pre-market approval of health food products, as such a move would require careful consideration by the community.

18. Mr Michael MAK said that in regulating health claims, a balance needed to be struck between protection of public health and survival of the trade. Mr MAK further said that one effective way to prevent consumers from buying products with misleading or exaggerated claims was for DH to step up its effort on public health education.

19. DDH agreed with Mr MAK's views and further said that DH had launched programmes to educate the public on the concept of health and the proper use of health products. Public education on this front would be continued and further stepped up when necessary.

20. Mr Andrew CHENG said that the law should not prohibit exaggerated claims as long as the claims were not completely unfounded, as exaggeration was a special characteristic of advertisement. Mr CHENG hoped that the Administration, in regulating health claims, would have regard to safeguarding Hong Kong's well regarded advertising industry and free flow of information. Mr CHENG then enquired whether health claims made by word of mouth would be regulated.

21. DDH shared Mr CHENG's view on an element of exaggeration in advertisement. The difficulty was in determining at which point a line should be drawn to protect public health. The Administration would consult the public and other stakeholders including the trade, the Consumer Council and medical professionals before finalising the list of prohibited claims. DDH further said that the spirit of the UMAO was to prohibit advertisements claiming that a product had curative or preventive effects on any of the diseases listed in the schedule to the Ordinance, regardless of whether the claims had bases. This was to prevent members of the public from delay in seeking proper medical treatment. On the question of whether health claims made orally would be regulated, DDH replied in the positive as the term "advertisement" meant "including any notice, poster, circular, label, wrapper or document, and any announcement made orally or by any means of producing or transmitting light or sound" in the UMAO.

22. Mr Andrew CHENG reiterated his view that exaggerated claims should not be prohibited as long as the claims were not completely unfounded. Mr CHENG further expressed concern about the difficulty in enforcing health claims made verbally. DDH admitted that it would be more difficult to enforce health claims

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made verbally than, say, those made through newspaper advertisements. However, a health claim made verbally would usually come with a leaflet advertising the health effects of the product. It would therefore be possible for the enforcement officers to use the leaflet as evidence of misleading or exaggerated claims, if any. Mr CHENG remarked that the problem was that the leaflet could say one thing while the seller could exaggerate the health claims of the product. DDH agreed to consider this point when drafting the legislation on regulation of health claims.

23. Miss CHAN Yuen-han said that in order not to undermine freedom of choice of consumers, regulation of health claims should not be too stringent so long as these claims would not cause harm to one's health.

24. DSHWF responded that it was not the Administration's intention to regulate health food as stringently as drugs. The proposal on regulation of health claims was drawn up in response to rising complaints from consumers against misleading or exaggerated claims of the so-called health food products. Regulation of health food products would thus focus on regulating their claims as a start. The Administration would decide later on whether there was a need to introduce a mechanism of pre-market approval in light of the operation experience of regulation of health claims.

25. Dr LAW Chi-kwong was of the view that claims relating to body functions should not be prohibited if these claims could be substantiated by clinical proof.

26. DDH explained that the reason for prohibiting health claims relating to body functions was to prevent improper self-medication by members of the public, thereby causing harm as result of either the improper self-medication itself, or the delay in seeking proper treatment. Therefore, the fact that a health food product could substantiate its claim, say, regulation of blood pressure, was beside the point. DSHWF added that an option that could be considered was to provide a second column in the new schedule to the UMAO to stipulate the purposes for which advertisements on health claims would be permitted.

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27. In summing up, the Chairman requested the Administration to consult members again after it had completed its public consultation on the prohibited claims before deciding on the way forward.

V. Working Group on Public/Private Interface - Progress Report
(LC Paper No. CB(2)554/02-03(03))

28. DSHWF took members through paragraphs 1 to 10 of the Administration's

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paper which reported on the progress made by the two Working Groups on Public/Private interface. Director (Professional Services & Public Affairs), HA (Director, HA) took members through paragraphs 11 to 15 of the same which set out Hospital Authority (HA)'s ongoing and future initiatives to enhance collaboration between the public and private sectors.

29. Miss CHAN Yuen-han and Dr YEUNG Sum said that the Administration was moving in the right direction in addressing the uneven distribution of workload between the public and private sectors. Nevertheless, they hoped that in doing so, no HA patient would be forced to use services provided by the private sector.

30. DSHWF assured members that no HA patient would be forced to use services provided by the private sector. Rather, HA patients would be provided with information on private hospitals or clinics to facilitate their consideration of referral options. The objective of promoting better interfacing between the public and private sectors was to facilitate a more efficient and effective distribution of work between the different levels and sectors of health care provision.

31. Director, HA also assured members that no HA patient would be forced to use services provided by the private sector. The reason for providing HA patients with a choice of using services provided by the private sector was to allow better off patients another choice in seeking treatment, so that any time and resources saved could be used on better helping patients who could not afford private services.

32. Ms Cyd HO asked the following questions -

(a) Whether there was any mechanism for former HA patients to appeal against the decisions of HA to refuse them use of HA services; and

(b) Whether there was any system in place for the Administration to monitor prices charged by private hospitals, as there were many complaints that prices eventually charged by private hospitals were higher than prices quoted at the beginning.

Ms HO further said that private patients of HA professorial doctors should not be allowed to pay fees at a heavily subsidised level for use of HA services.

33. DSHWF responded that although the Administration did not have the power to intervene into how private hospitals should charge their patients, actions had been and would continue to be taken to encourage operators of private hospitals to make their prices more transparent and to develop more set cost

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services. DSHWF pointed out that increasingly more and more operators of private hospitals were well aware of the need to have a more transparent price list, so as to attract more patients to use their services.

34. Director, HA said that HA would never turn away patients, including those who had chosen to use the services provided by the private sector for follow-up treatment. Director, HA further said that under the patient referral system, the priority of the public specialist out-patient services would be defined by "medical triage", i.e. appointments for a patient would be allocated according to the degree of urgency of his/her clinical condition instead of first-come-first-served as at present. Director, HA reiterated that patients would be given a choice to seek treatment from the private sector. To this end, HA would publicise in its hospitals and clinics a list of private hospitals and clinics from which patients could seek treatment if they so wished. Such a list would be provided by professional groups to ensure the authenticity of the information provided and impartiality on the part of HA.

35. Regarding the comments made that private patients of HA professorial doctors should not be allowed to pay heavily subsidised fees for use of HA services, Director, HA said that there was no problem if these patients used public ward in-patient service in HA hospitals. Director, HA added that after the current moratorium on public fees was lifted, private services provided by HA would be charged at market rates, or at least equal to the full costs of providing these services. There was therefore no question of public money subsidising patients using HA private services. HA however had no intention to expand its private services, which at present only represented a very small percentage of HA services.

36. Responding to Ms HO's enquiry as to how many private patients of HA professorial doctors had used the private rooms in the public wards, Director, HA said that the use of such rooms were based on medical needs. Director, HA further said that if patients were users of private services, they would use the private wards of HA.

37. At the request of the Chairman, Director, HA undertook to provide statistics on the use of HA private services in the past year, including the number of patients who had used the private services and the types of services they used.

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38. Mr Andrew CHENG noted that the number of members from the private sector on the Working Group on Interface between Medical Practitioners in the Public/Private Sectors (the Working Group) outnumbered that from the public sector by four. Mr CHENG enquired whether the Administration would be pressurised to increase the accident and emergency (A&E) fee in public hospitals

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since there was no marked reduction of the utilisation of A&E service in public hospitals after the introduction of the A&E charge on 29 November 2002.

39. DSHWF responded that the Working Group did not discuss fees and charges of public hospitals, as the subject matter was outside the terms of reference of the Working Group. DSHWF clarified that the nine members of the Working Group who were medical practitioners were not all private practitioners.

40. DSHWF further said that it was still too early to say whether the introduction of the A&E charge had failed to achieve its desired effect. In determining whether the A&E fee in public hospitals should be increased, the Administration would seek the views from all sectors of the community. Factors such as the affordability of the public and the impact of the proposed increase in A&E fee on government as well as private out-patient clinics would be taken into consideration. The Chairman requested the Administration to brief members in three months' time on the effect of the A&E charge on the A&E service. DSHWF agreed.

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41. Mr Michael MAK declared that he was a HA employee. Mr MAK then asked the following questions -

(a) What was the Administration's target of the distribution of workload between the public and private sectors in terms of hospital services;

(b) What was HA's legal liability if a HA patient's condition became worse immediately or shortly after using the services provided by the private sector; and

(c) What were HA's criteria for selecting the private hospitals or clinics to which HA referred its patients for follow-up treatment.

42. DSHWF responded that no target of distribution of workload between the public and private sectors had been or would be set. The enhancement of collaboration with the private sector was an ongoing initiative, the objectives of which were to achieve better distribution of workload and improve efficiency in the use of available health resources. As regards Mr MAK's second question, DSHWF said that HA should not be held liable for any adverse effect of treatment of its former patient by the private hospital or medical practitioner as the decision to go to the private sector for follow-up treatment was the decision of the patient. The only responsibility of HA was to provide patients with as accurate information as possible.

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43. As to Mr MAK's last question, Director HA said that HA had no formal partnership with the private sector under the patients referral system, except under the collaborative models of service provision in individual specialties as set out in paragraph 11(b) of the Administration's paper.

44. Ms LI Fung-ying said that HA should not turn away patients who wished to use HA services again after they had been treated by private providers. Director HA reiterated that this would not happen.

45. On concluding the discussion, the Chairman said that members' major concern was that no barrier should be laid down to deter patients from entering the public health care system after they had previously opted to use services provided by the private sector. The Panel would follow up the matter if this situation should occur.

VI. Clinical Trial Scheme for Patients with Chronic Myelogenous Leukaemia

46. The Chairman said that on 6 December 2002, Duty Roster Members had met with a group of patients who had been on the clinical trial programme of a new drug called "Glivec" for the treatment of chronic myelogenous leukaemia (CML). Owing to the extremely high price of Glivec, these 18 patients hoped that the manufacturer would continue to provide the new drug to them free of charge. A case conference with the Administration was being arranged to discuss the possibility of HA introducing Glivec in public hospitals. The Chairman then referred members to a submission from the 18 patients who had been on the clinical trial programme of Glivec tabled at the meeting.

47. DSHWF responded that it was Government policy that no one would be denied adequate medical care for lack of means. Nevertheless, there was a need for HA to balance the cost effectiveness and the clinical benefits of the drugs to patients before introduction with an aim to better target the limited public resources to the most needy.

48. Director, HA said that HA would introduce Glivec for treatment of CML in public hospitals. HA had made reference to the guidelines of the National Institute of Clinical Excellence (NICE) of the United Kingdom and prepared a set of clinical guidelines for prescription of Glivec in public hospitals. In view of the extremely high price of Glivec, HA had been in discussion with the manufacturer in the past few months to lower the price of the new drug for the benefits of CML patients. To date, two charitable organisations had agreed to sponsor HA patients who had financial difficulty in paying for Glivec on their

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own. Director, HA further said that the manufacturer of Glivec had indicated to HA that it would continue to provide the new drug to the 18 patients who had been on the clinical trial programme free of charge at least until January 2003. At the request of the Chairman, Director, HA undertook to provide information on the amount of money available for application for financial assistance to pay for Glivec and the eligibility criteria.

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49. Dr YEUNG Sum urged the early introduction of Glivec in public hospitals and called upon the manufacturer to continue to provide the new drug to the 18 patients who had been on the clinical trial programme free of charge.

50. Mr LEE Cheuk-yan said that it would be unethical of the manufacturer if it stopped providing Glivec to the 18 patients who had been on the clinical trial programme free of charge. Mr LEE further said that HA should introduce Glivec in public hospitals as soon as possible, since the effectiveness of the new drug to treat CML had been recognised by NICE and the new drug had been registered in Hong Kong. Mr LEE was however of the view that HA should provide Glivec to its patients free of charge, as many could not afford the high price of the drug.

51. Miss CHAN Yuen-han said that the manufacturer of Glivec should be condemned if it stopped providing Glivec to the 18 patients who had been on the clinical trial programme free of charge. Miss CHAN suggested that if that was the case, HA should retaliate by not buying other drugs from the manufacturer concerned.

52. Mr Andrew CHENG said that it was unrealistic to expect drug manufacturers to be ethical. A better approach would be to provide a safety net for patients with CML.

53. Mr Michael MAK said that as human lives were invaluable, HA should not skim its spending on introducing new drugs in public hospitals. To this end, Mr MAK urged the Secretary for Health, Welfare and Food to take up with the Financial Secretary that HA should be not be required to achieve a saving of 1.8% in operating expenditure in 2003-04 and 1% each year from 2004-05 to 2006-07.

54. Director, HA assured members that HA would introduce Glivec in public hospitals after an agreement had been reached with the manufacturer on the price of the drug. As an accountable organisation utilising public money, it was incumbent upon HA to consider the cost when introducing new drugs, which had a tendency to be on the high side, in public hospitals.

55. On closing, the Chairman said that the Panel would continue to keep on eye on the development of the matter. Members were welcomed to join the case

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conference with the Administration to follow up the matter if they so wished.

VII. Any other business

56. There being no other business, the meeting ended at 10:50 am.

Council Business Division 2
Legislative Council Secretariat
9 January 2003