# *立法會*
# *Legislative Council*

LC Paper No. CB(2)1393/02-03
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

**Panel on Health Services**

**Minutes of meeting**
**held on Monday, 10 February 2003 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 CHAN Kwok-keung<br>Hon CHAN Yuen-han, JP<br>Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP<br>Hon Andrew CHENG Kar-foo<br>Dr Hon TANG Siu-tong, JP<br>Hon LI Fung-ying, JP |
| **Members Absent** | : | Hon Albert HO Chun-yan<br>Dr Hon YEUNG Sum<br>Dr Hon LAW Chi-kwong, JP |
| **Public Officers Attending** | : | All items<br><br>Mr Thomas YIU, JP<br>Deputy Secretary for Health, Welfare and Food<br><br>Miss Angela LUK<br>Principal Assistant Secretary for Health, Welfare and Food (Health) |

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Mr Tony CHAN
Assistant Secretary for Health, Welfare and Food (Health)

Item IV

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

Dr K M CHOY
Executive Manager (Professional Services), Hospital Authority

Item V

Dr P Y LAM, JP
Deputy Director of Health

Mr T W CHEUNG
Senior Pharmacist (Traditional Chinese Medicine)
Department of Health

**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)1074/02-03)

The minutes of the special meeting held on 13 January 2003 were confirmed.

**II. Information paper issued since the last meeting**
(LC Paper No. CB(2)1052/02-03(01))

2. Members noted the letter dated 18 January 2003 from the Hang Lung Trading (H.K.) Ltd. on the Government Supplies Department and the Hospital

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Authority (HA)'s tender requirements for pharmaceutical products, and did not raise any query. The Chairman informed members that the matter was presently being followed up by the Administration.

## III. Items for discussion at the next meeting
(LC Paper Nos. CB(2)1105/02-03(01) and (02))

3. Members agreed to discuss the following items at the next regular meeting scheduled for 10 March 2003 -

(a) Remodelling of Tuen Mun Polyclinic into an Ophthalmic Centre; and

(b) Effect of the accident and emergency (A&E) charge on A&E service in public hospitals.

4. In addition to the two issues mentioned in paragraph 3 above, Mr Michael MAK and the Chairman separately proposed to discuss the issues of termination of the appointment of serving temporary workers at the Hospital Authority (HA) and HA doctors on contract term in March 2003. Deputy Secretary for Health, Welfare and Food (DSHWF) agreed to consider these requests.

5. Ms Cyd HO requested the Administration to provide a paper on measures to address the deficit problem of HA, prior to the delivery of the 2003-04 Budget Speech by the Financial Secretary (FS) on 5 March 2003. Ms HO also requested the Administration to provide a paper on the medical fee waiver scheme, prior to the revision of the fees and charges of hospital services other than A&E service at public hospitals on 1 April 2003.

6. DSHWF responded that he could not accede to Ms HO's first request, as measures to address the deficit problem of HA would need time to develop and would probably not be firmed up until after FS had delivered his 2003-04 Budget Speech on 5 March 2003. Nevertheless, it was the Administration's plan to brief members on the financial situation of HA, including measures to address HA's deficit problem, in the second quarter of 2003. As regards the fee waiver scheme, DSHWF said that the Administration planned to apprise members of its thinking on the scheme at the special meeting scheduled for 24 February 2003. Ms HO remarked that there might be a need to convene a special meeting to discuss measures to address the deficit problem of HA, as Members might not have enough time to thoroughly discuss the subject matter at the relevant special Finance Committee meeting.

7. Mr Andrew CHENG proposed and members agreed to include the review

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of provision of legal aid to patients claiming compensation in medical incident cases in the outstanding list of issues for discussion.

## IV. Provision of Chinese medicine service in the public sector
(LC Paper No. CB(2)1105/02-03(03))

8. The Chairman expressed dissatisfaction that the above Administration's paper only reached the Secretariat in the evening of 7 February 2003, and reminded the Administration of the need to provide papers much earlier. DSHWF apologised for the lateness, which was partly due to the intervening Lunar New Year holidays.

9. DSHWF then took members through the plan to introduce Chinese medicine into the public health care system, details of which were given in the Administration's paper. Director, HA supplemented that the wide use of Chinese medicine in Hong Kong both as an alternative and a complement to western medicine had necessitated the need to develop models of interface between western and Chinese medicine. The main reason for the present highly compartmentalised delivery of western and Chinese medicine was due to the lack of a strong scientific basis for evaluating clinical efficacy in Chinese medicine practice, an element which was essential for interfacing with western medicine. As primary care was one of the strengths of Chinese medicine, providing Chinese medicine service in the public sector was thus the logical first step in developing models of interface between western and Chinese medicine. To this end, HA would collaborate with those non-governmental organisations (NGOs) with ample experience in providing Chinese medicine services as well as tertiary institutions having established capacity in research and training.

10. Ms LI Fung-ying said that charging a fee of $120 for Chinese medicine out-patient service (comprising $80 for consultation fee and $40 for medication) was too high, given that general out-patient (GOP) and specialist out-patient (SOP) services only charged a fee of $37 and $44 for each consultation, or $45 and $60 from 1 April 2003 after the current moratorium on public fees was lifted. In the light of this, Ms LI asked whether consideration would be given to lowering the fee for Chinese medicine out-patient service. Noting the Administration's plan to develop regulatory standards for another 52 commonly used Chinese medicinal herbs in Hong Kong from 2003, Ms LI queried whether this would conflict with the introduction of Chinese medicine into the public health care system.

11. DSHWF responded that setting the fee at $120 for Chinese medicine out-patient service was made having regard to the current level of charges in the market and patients' affordability. Patients having difficulty in paying the $120

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fee could apply for partial or total fee waiver from HA. DSHWF explained that the reason for setting the fee comparable to the average level of charges in the market was to avoid competing with the private sector which currently already provided generally comprehensive and affordable Chinese medicine services in the community. Unlike GOP and SOP services, the delivery of Chinese medicine out-patient service would be on a limited scale and that the focus was not on treating illnesses. Notably, only 18 Chinese medicine out-patient clinics were planned to be set up. Apart from promoting the development of "evidence-based" Chinese medicine practice through clinical research, clinical services provided at the clinics would help to derive the experience and expertise to systemise the knowledge base of Chinese medicine and develop standards in Chinese medicine practice. The participation of western medical practitioners in the joint clinical teams would help develop models of interface between western and Chinese medicine. Moreover, the clinics would serve as training grounds for Chinese medicine practitioners, particularly those graduates of local universities.

12. DSHWF further said that there was no conflict between the introduction of Chinese medicine into the public health care sector and the development of regulatory standards for commonly used Chinese medicine herbs in Hong Kong. Rather, these two initiatives were complementary to each other.

13. Ms LI Fung-ying expressed concern that the charging of a fee of $120 per consultation for Chinese medicine out-patient service might lead to an increase in the fee charged by Chinese medicine clinics operated by NGOs. In response, DSHWF said that there was no cause for such a concern. In fact, the fee charged by some Chinese medicine clinics operated by NGOs was higher than $120. A case in point was the Chinese medicine clinic operated by Kwong Wah Hospital in collaboration with The Chinese University of Hong Kong (CUHK). Although some Chinese medicine clinics operated by NGOs charged a fee lower than $120, such as that operated by Yan Chai Hospital which only charged a fee of $30 per consultation (excluding medication), DSHWF explained that this was because these clinics primarily provided treatment to common ailments and did not engage in clinical research. DSHWF further said that if HA should decide to collaborate with, say, the Kwong Wah Clinic and the Yan Chai Clinic, in the delivery of research-oriented Chinese medicine service, the fee currently charged by these clinics would be revised to the level proposed for the public sector Chinese medicine clinics.

14. Mr Andrew CHENG expressed concern that charging a fee of $120 for each consultation would turn the Chinese medicine out-patient clinics into white elephants. In view of the fact that the fees for GOP and SOP services under HA were considerably less than those in the private sector, Mr CHENG asked why the Administration considered it appropriate to set the fee for Chinese medicine out-

patient service at $120 so as not to compete with the service providers in the private sector. Assuming that setting the fee for Chinese medicine out-patient service at a level so as not to compete with the private sector was appropriate, Mr CHENG considered that the fee should at least be comparable to the median, rather than the average, charge in the market which was around $90 as mentioned by DSHWF in his introduction. If that was not the case, this was tantamount to making the service into a profit-making venture. Noting that the $40 medication fee included in the $120 fee would comprise two doses of medication, Mr CHENG said that one way to drive the fee down to a more affordable level was to allow patients to choose one dose of medication.

15. DSHWF disagreed that charging a fee of $120 would turn the Chinese medicine out-patient clinics into white elephants, as evidenced by the high demand for the Chinese medicine service provided by Kwong Wah Clinic which charged a fee higher than $120 if medication was included. DSHWF also disagreed that charging a fee of $120 would make the Chinese medicine out-patient service a profit-making service. The Chinese medicine out-patient service would be subsidised by the Government, though not to a level as high as that for GOP and SOP services which were presently around 90% subsidised. On the suggestion that the fee for Chinese medicine out-patient service should be comparable to the median, rather than the average, charge in the market, DSHWF said that this was debatable. As to why the fee was set at $120 so as not to compete with the service providers in the private sector, DSHWF reiterated the explanations given in paragraph 11 above. DSHWF further said that providing patients with two doses of medication was reasonable, having regard to the fact that patients normally needed to take two doses of medication to see any improvement to their health.

16. In response to the Chairman, DSHWF said that the level of subsidy to Chinese out-patient service was 37%, given that the cost per attendance was $190 if the element of research was excluded. The level of subsidy would be 52% if the research element was included in the operating cost.

17. Mr Andrew CHENG remained of the view that the charge of $120 was too high to attract patients. To avoid the problem of under-utilisation, Mr CHENG suggested not to charge patients for using the Chinese medicine out-patient clinics at the beginning, as some of them would be used as guinea pigs in research oriented programmes.

18. DSHWF responded that he was confident that the Chinese medicine out-patient clinics would be welcomed by the public, as its fee was comparable to the average fee charged by the private sector. A review on the implementation of the Chinese service out-patient service, including whether the fee was set at an

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appropriate level, would be conducted in the light of the operational experience of the three clinics to be set up in 2003. Director, HA also said that describing patients selected to join research oriented programmes as guinea pigs was unfair to the researchers. Firstly, many patients who failed to get any improvement from western medicine treatment for their chronic or terminal diseases had the desire to seek alternative treatment from Chinese medicine. If HA did not refer them for Chinese medicine treatment, they would do so on their own. Secondly, patient's consent would be sought as to whether he/she was willing to join the research oriented progammes. Thirdly, research oriented programmes were not experimental in nature, and were governed by guidelines intended to develop the knowledge base and standard of practice of Chinese medicine.

19. Mr Michael MAK said that he had participated in the Panel visit to the Chinese medicine clinic at Kwong Wah Hospital last year. He noted that there was no shortage of patients even though a higher fee than that proposed for the new clinics was charged. He therefore was of the view that the Chinese medicine clinics to be provided in the public sector would also prove very popular. Mr MAK then asked the following questions -

(a) What percentage of HA funding would be spent on providing Chinese medicine service in the public sector;

(b) Whether Chinese medicine service in the public sector would cover acupuncture and naprapathy;

(c) Whether there were adequate Chinese medicine practitioners experienced in clinical research to achieve the objectives of providing Chinese medicine service in the public sector;

(d) Whether the information technology (IT) system referred to in paragraph 9 of the Administration's paper could access HA's clinical information systems; and

(e) Whether sickness day certified by registered Chinese medicine practitioners would be recognised under labour legislation.

20. DSHWF responded that providing Chinese medicine service in the public sector would not take away existing HA resources, as separate resources had been set aside to fund the service. The total cost of setting up 18 Chinese medicine out-patient clinics was about $100 million a year. As regards the recognition of sickness day certified by Chinese medicine practitioners under labour legislation, DSHWF said that legislative amendments to this effect would be introduced into the Legislative Council. The Chairman said that the Panel on Manpower had

discussed the proposal to recognise Chinese medicine for entitlement to employee benefits on 16 May 2002. He asked the Secretariat to provide members with the relevant minutes of meeting after the meeting.

21. Director, HA said that including acupuncture and naprapathy in Chinese medicine service in the public health care system would be considered at a later stage. As to the question of manpower, Director, HA said that there should be no great difficulty in recruiting adequate Chinese medicine practitioners experienced in clinical research to achieve the objectives of providing Chinese medicine in the public sector, as the number involved was not great. Director, HA further said that the IT system developed for public Chinese medicine out-patient clinics could not access HA's clinical information systems. Nevertheless, HA had plan to develop a system which would provide information to both western and Chinese medicine practitioners on the effect of certain commonly used Chinese medicine on patients taking western medicine.

22. Responding to Mr MAK's further enquiry about the functions of the tertiary toxicology laboratory at Princess Margaret Hospital, Director, HA said that they were twofold. Firstly, databases on the toxicological aspects of Chinese medicine for access by all frontline clinicians via HA's Intranet would be developed. Secondly, patient-based expert assessment and advice would be provided to all frontline clinicians who encountered patients with suspected poisoning after taking Chinese medicine.

23. Ms Cyd HO expressed concern that charging a fee of $120 for Chinese medicine out-patient service would give rise to fee increase in the market. Moreover, the huge differences in fees between Chinese medicine out-patient service and GOP/SOP services was not conducive to interfacing of western and Chinese medicine. Ms HO then asked the following questions -

(a) What were the reasons for the difference in the level of subsidy to Chinese medicine out-patient service and GOP/SOP services;

(b) How many consultations each Chinese medicine out-patient clinic under HA would handle per day; and

(c) At what point would western medicine practitioners join their Chinese medicine counterparts in treating patients at the Chinese medicine out-patient clinics.

Ms HO further said that information contained in the IT system for the development of evidence-based Chinese medicine and clinical research and development should be bilingual, so as not to restrict Chinese medicine practice to

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people knowing the Chinese language.

24. Responding to the comments made by Ms HO's regarding the fee for Chinese medicine out-patient service provided by HA, DSHWF reiterated the reasons for setting the fee at such a level given in paragraph 11 above. Moreover, as the public sector would only take up 5% to 6% of the Chinese medicine service market when all the 18 Chinese medicine out-patient clinics under HA were set up, it was highly unlikely that the fee of $120 charged by HA would give rise to fee increase by the service providers in the private sector. Although the Chinese medicine out-patient clinic operated by Kwong Wah Hospital in collaboration with CHUK, which was perceived by the public as a public clinic, charged a fee higher than $120, this did not lead to any fee increase by service providers in the private sector. DSHWF further reiterated that to ensure that the fee of $120 was set at an appropriate level which would not compete with the market on the one hand and could attract a sufficient number of patients on the other, a review would be conducted after the first three clinics had come into operation for some time. As to the number of consultations each Chinese medicine out-patient clinic would handle each year, DSHWF said that it would be around 30 000.

25. In reply to Ms HO's last question, Director, HA said that patients would be treated by Chinese medicine practitioners in the first instance. Those considered not suitable for joining the research oriented programmes would be provided with appropriate management of their presenting conditions on a one-off basis, whilst others would be invited to join research oriented programmes. All patients who agreed to participate in research oriented programmes would be followed up by a dedicated team of health care professionals which could include western and Chinese medicine practitioners depending on the protocol. Director, HA further said that there would also be instances whereby some patients would be referred to western medicine practitioners for treatment. As regards the suggestion that information contained in the IT system for the development of evidence-based Chinese medicine and clinical research and development should be bilingual, Director, HA undertook to convey such to the system development team for consideration.

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26. At the request of Ms Cyd HO, DSHWF undertook to provide information on the fees and charges of Chinese medicine service providers in the private sector.

27. Dr TANG Siu-tong asked the following questions -

(a) Who would lead the research oriented programmes and whether there was any time-limit for the programmes;

(b) Whether the Chinese medicine out-patient clinics would only treat diseases not treatable by western medicine, given that the primary objective of these clinics was to develop "evidence-based" Chinese medicine practice through clinical research; and

(c) What was the reason for including medication in the fee for Chinese out-patient service.

28. Director, HA responded that depending on the nature of the research project and the composition of each research team, each project could be led by either western medicine practitioners from HA, Chinese medicine practitioners from the Chinese out-patient clinics or academics from the tertiary institutions. No time-limit would be set for the research project. However, it was envisaged that each project would take about several months to two years to complete. Director, HA further said that although the Chinese medicine out-patient clinics were research oriented, these clinics would treat anyone coming to seek treatment. As to the reason for including medication in the charge for Chinese medicine out-patient service, Director, HA explained that this was to ensure that patients participating in the research oriented programmes were taking medication as prescribed. If that was not the case, the accuracy of research findings would be undermined.

29. Miss CHAN Yuen-han expressed support for developing "evidence-based" Chinese medicine practice through clinical research. Miss CHAN, however, urged the Administration to ensure that the provision of Chinese medicine in the public sector would not result in the public sector being the main service provider.

30. DSHWF responded that there was no question that the public sector would become a main service provider of Chinese medicine. This was evidenced by the facts that the Administration had no intention to set up more Chinese out-patient clinics beyond the 18 clinics planned, and the charge for Chinese out-patient service was deliberately set a at level not to compete with the private sector. DSHWF pointed out that although the total number of consultations to be provided by all 18 clinics would come up to over 500 000 a year, the public sector would only take up 5% to 6% of the market. Director, HA supplemented that in order to avoid the problem of patient volume being built up at the Chinese medicine out-patient clinics, patients not selected to join the research oriented programmes would need to obtain the chit for consultation on the day without the option of pre-booked appointments.

31. Ms Cyd HO asked about the criteria for determining which clinical areas to be selected for research. Ms HO further asked when Chinese medicine would be introduced into hospital services in the public health care system, as this was integral to the development of evidence-based methodology in the development of

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Chinese medicine.

32. Director, HA responded that each Chinese medicine out-patient clinic would have a number of clinical research protocols on Chinese medicine formulated with the input from western medicine practitioners from HA, Chinese medicine practitioners from the Chinese out-patient clinics and academics from the tertiary institutions in accordance with established principles on clinical research adopted in western medicine. Approval would need to be obtained from HA's Ethics Committee before these protocols could be put into practice. Director, HA further said that HA had no plan to introduce in-patient Chinese medicine services in the public health care system. Director, HA, however, pointed out that the lack of Chinese medicine hospital services would not impede the development of evidence-based Chinese medicine practice, as evidenced by the fact that a significant amount of clinical research on western medicine were primarily based on out-patient clinics.

33. On closing, the Chairman said that the Administration should report to the Panel after the three Chinese out-patient clinics, to be set up this year, had come operation for some time.

## V. Development of regulatory standards for Hong Kong Chinese medicinal herbs

(LC Paper No. CB(2)1105/02-03(04))

34. Deputy Director of Health (DDH) briefed members on the Administration's plan to develop regulatory standards for commonly used Chinese medicinal herbs (herbs) in Hong Kong as detailed in the Administration's paper.

35. Mr CHAN Kwok-keung expressed concern about the long time required for completing the development of regulatory standards for only 60 herbs. Noting that many universities and research institutions had conducted numerous research studies on herbs, Mr CHAN asked why the Department of Health had not considered drawing reference from these studies so as to expedite the development work. Ms LI Fung-ying echoed similar views.

36. DDH responded that the reason why the development of regulatory standards for 60 commonly used herbs required several years to complete was because there was presently no international standards regarding the safety and quality of the herbs, despite the fact that many universities and research institutions in the Mainland and overseas had conducted studies on herbs. For instance, in the Mainland, the adoption of standard for herbs had taken into account varying economic development of different localities and was therefore

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not applicable to Hong Kong. The development of internationally recognised regulatory standards for herbs in Hong Kong would cover sources and description of herbs, identification (such as microscopic examination and chromatographic analysis), tests (such as heavy metal and pesticide residues), extractive, assay, etc. DDH further said that although the number of herbs numbered over thousands, the Administration only planned on developing regulatory standards for 200 herbs which were the commonly used ones in Hong Kong. It was hoped that after gaining some practical experience in developing the regulatory standards for 60 commonly used herbs, the time required for developing the same for the remaining 140 herbs could be shortened.

37. Miss CHAN Yuen-han said that in developing the regulatory standards for commonly used herbs in Hong Kong, the Administration should also examine how this could be linked with the development of proprietary Chinese medicines, so as to help Hong Kong to become an international centre for Chinese medicine.

38. Noting the all the research and laboratory works for the development of regulatory standards for herbs in Hong Kong would be carried out locally, Mr Michael MAK asked whether Hong Kong had the requisite expertise. Mr MAK further asked how the regulatory standards would be adopted, say, by the Chinese medicine out-patient clinics

39. DDH replied in the positive to Mr MAK's first question, and referred members to paragraphs 9 to 11 of the Administration's paper which detailed the stringent control on the development of regulatory standards and the benefit to different sectors of the community. As to how the regulatory standards would be adopted in the public health care system, DDH said that the standards would provide a basis for procuring herbs which were safe and of high quality.

## VI. Any other business

40. In response to the Chairman, DSHWF said that the Administration would provide a written response to the views and concerns expressed by members on the liver transplant arrangements of HA at the meeting held on 21 January 2003 within the week.

41. There being no other business, the meeting ended at 10:40 am.

Council Business Division 2
Legislative Council Secretariat
5 March 2003