立法會
Legislative Council

LC Paper No. CB(2)1735/02-03
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 10 March 2003 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 Albert HO Chun-yan Hon CHAN Kwok-keung 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
Members Absent	:	Hon CHAN Yuen-han, JP Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP
Member Attending	:	Hon Fred LI Wah-ming, JP
Public Officers Attending	:	All items Mr Thomas YIU, JP Deputy Secretary for Health, Welfare and Food

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Mr Nicholas CHAN
Assistant Secretary for Health, Welfare and Food

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

Item III

Mrs Ingrid YEUNG
Principal Assistant Secretary for Health, Welfare and Food

Items IV to VI

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

Item IV

Dr CHENG Man-yung
Deputy Director (Professional Services And Facilities Management)
Hospital Authority

Mr Donald LI
Executive Manager (Hospital Planning), Hospital Authority

Item VI

Dr LIU Shao-haei
Senior Executive Manager (Professional Services)
Hospital Authority

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)1393/02-03)

The minutes of meeting held on 10 February 2003 were confirmed.

II. Items for discussion at the next meeting
(LC Paper Nos. CB(2)1397/02-03(01) and (02))

2. Deputy Secretary for Health, Welfare and Food (DSHWF) said that the Administration was in a position to discuss the issue of regulation of medical devices at the next regular meeting scheduled for 14 April 2003. As to other items for discussion in April, DSHWF said that he would inform the Secretariat after the meeting.

3. The Chairman asked whether the Administration was in a position to discuss the arrangement for registration assessment for listed Chinese medicine practitioners in April 2003, having regard to the numerous complaints received on the matter. DSHWF agreed to consider the matter and revert to the Secretariat after the meeting. Ms Cyd HO said that the discussion should also include the issue of part-time Chinese medicine students of the Hong Kong Baptist University and the University of Hong Kong not allowed to sit for the licensing examination despite the fact that they had undergone 2 000 hours of training.

4. Responding to the Chairman's further enquiry on the timing for discussing the proposed amendments to the Smoking (Public Health) Ordinance, DSHWF said that the Administration might be in a position to discuss the matter in May 2003.

5. Before proceeding to the next item, the Chairman invited the Administration to give a response to the concerns/suggestions raised by members and deputations regarding the enhanced fee waiver mechanism at the special meeting held on 24 February 2003.

6. DSHWF responded that the Administration had carefully considered the concerns/suggestions raised by members and deputations at the special meeting held on 24 February 2003. The Secretary for Health, Welfare and Food would respond to such and others in his speech during the motion debate on the medical fee waiver mechanism at the Council meeting on 12 March 2003.

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III. Effect of the charge on accident and emergency service in public hospitals
(LC Paper No. CB(2)1397/02-03(03))

7. Director, Hospital Authority, (Director, HA) briefed members on the effect of the new accident and emergency (A&E) charge on the A&E service, details of which were set out in the Administration's paper.

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

(a) What types of patients, referred to in paragraph 11 of the Administration's paper, were granted wavier of A&E fee; and

(b) What types of patients, referred to in paragraph 10 of the Administration's paper, were unable to settle their A&E payment upon registration.

9. Director, HA believed the types of patients who were granted waiver of A&E from December 2002 to February 2003 were mainly the low income group, chronically ill and elderly patients with limited income/assets and not on public assistance. As to Dr TANG's second question, Director, HA said that he did not have the answer. Director, HA, however, pointed out that it was not surprising that 32% of the patients who were issued payment advices from December 2002 to January 2003 had not yet settled their A&E payment, having regard to the hectic life style led by many Hong Kong people. If these payments remained outstanding, HA would initiate its usual debt recovery procedures to collect them.

10. Responding to Dr TANG's further enquiry as to why some applications for waiver of A&E fee were rejected, Director, HA said that he believed that this was because the medical social workers considered that the income and asset of the patients concerned could afford the A&E fee. The Chairman advised that the eligibility and assessment criteria for full or partial waiver of public medical fees were set out in the Administration's paper (LC Paper No. CB(2)1245/02-03(05)) for the special meeting on 24 February 2003.

11. Noting that the number of emergency cases and unclassified cases had decreased by 0.1% and 62.2% respectively between December 2002 and January 2003 compared with the period from December 2001 and January 2002, Ms LI Fung-ying asked why this was the case. Ms LI further asked about the administrative cost for recovering outstanding A&E payments.

12. Director, HA responded that there was no indication that a decrease of 0.1% in the number of emergency cases was due to the introduction of the new A&E charge, as slight fluctuations in the number of emergency cases from month

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to month were a common phenomenon. Director, HA further said that although a decrease of 62.2% in the number of unclassified cases appeared high, these cases only represented a very small percentage of the total number of A&E attendances. As to Ms LI's second question, Director, HA said that the cost for recovering outstanding A&E payments would not entail any significant increase in HA's administrative cost, having regard to the facts that the number of outstanding A&E bills were not high and that an office had long been in place to handle outstanding bills prior to the introduction of the new A&E charge on 29 November 2002.

13. Ms LI Fung-ying hoped that the Administration would continue to closely monitor the effect of A&E charge on A&E service, as there had been concern that some patients might refrain from seeking treatment because of lack of means.

14. DSHWF responded that the Administration would continue to closely monitor the effect of A&E charge on A&E service. DSHWF, however, pointed out that there was no cause for concern that people would refrain from seeking treatment at HA's A&E departments because they could not afford the $100 fee, as evidenced by the fact that the number of critical and urgent cases had increased by 15% and 0.3% respectively from December 2002 to January 2003 compared with the figure from December 2001 to January 2002.

15. Mr CHAN Kwok-keung asked whether consideration could be given to allowing A&E fee to be paid by Octopus card. Mr CHAN further said that there had been complaints that A&E patients, who visited HA's A&E departments in the evening, had to return the following day to get their medications due to the closure of the dispensary. Given that patients were now charged $100 per A&E attendance, HA should actively consider arranging dispensers to work at the A&E department around the clock so that A&E patients did not need to return the following day to get their medications. Mr CHAN also hoped that the time needed for patients to get drugs at the public specialist out-patient (SOP) clinics could be shorteneDirector, HAving regard to the fact that HA intended to charge $10 per drug item on 1 April 2003 when the current moratorium on public fees was lifted.

16. Director, HA responded that HA was actively exploring various electronic payment methods for patients to settle their medical bills, including the use of Octopus card. On the suggestion of arranging dispensers to work at the A&E department around the clock, Director, HA said that this was not necessary as the primary objective of A&E service was to treat patients in critical and life-threatening conditions who would invariably be hospitalised. For those A&E patients deemed not necessary to be hospitalised, interim supply of general medications, which were prepared in advance by the dispensary, would be provided according to their medical needs. As to shortening the time needed for patients to pick up their medication after seeing doctors at public SOP clinics,

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Director, HA said that HA was currently looking at ways to see how this process could be expedited.

17. Mr Andrew CHENG disagreed that there was no cause for concern that some patients might delay or refrain from seeking treatment at HA's A&E departments because of lack of means, having regard to the fact that there had been a decrease of 10.7% in the number of semi-urgent cases from December 2002 to January 2003 compared with the figure from December 2001 to January 2002.

18. Director, HA responded that a decrease of 10.7% in the number of semi-urgent cases was a proof that the introduction of a new A&E charge had been effective in diverting patients not in critical and life-threatening conditions to use alternative modes of medical services that best suited their needs, thereby freeing up valuable resources at A&E departments to attend to genuine emergency cases. For instance, patients in semi-urgent and non-urgent conditions had been advised to see their own family doctors. To ensure proper use of A&E service in public hospitals, more work would be undertaken by HA to educate the public in this regard. At the request of the Chairman, Director, HA undertook to provide the definitions of various triage categories after the meeting.

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19. Mr Michael MAK said that expectation of patients to be treated expeditiously upon arriving at HA's A&E departments after the introduction of the new A&E charge had given rise to many conflicts between them and frontline health care workers. In the light of this, Mr MAK hoped that HA would step up its efforts on educating the public about the nature of A&E service on the one hand and provide more training to frontline health care workers on handling complaints from patients on the other. Mr MAK then asked about the measures which would be taken by HA to ensure that its A&E service would be used on treating patients in at least semi-urgent conditions in the long run.

20. Director, HA reiterated that more work would be undertaken by HA to educate the public that A&E service was aimed at treating patients in critical and life-threatening conditions. The fact that patients had paid a $100 fee for A&E service did not necessarily mean that they would receive immediate treatment. Director, HA clarified that the triage system adopted by HA had remained unchanged after the introduction of the new A&E charge. There was no question of patients not in urgent conditions having to wait a longer time than prior to the introduction of the new A&E charge. In fact, given the decrease in the number of semi-urgent and non-urgent cases after the introduction of the new A&E charge, the average waiting time for patients in urgent condition to receive treatment should have been shortened. Director, HA further said that in order to encourage patients in semi and non-urgent conditions to use medical services provided by the private sector, HA had and would continue to encourage private providers to

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extend their consultation hours to better meet patients' demand. To his understanding, more and more family medicine doctors in the private sector had extended their consultation hours to better meet patients' demand. Mr MAK remarked that another way to reduce improper use of A&E service was for general out-patient clinics to also provide 24-hour non-emergency treatment.

21. Ms Cyd HO asked the following questions -

(a) Whether the average waiting time of patients in critical, emergency and urgent conditions at HA's A&E departments had been shortened after the introduction of the new A&E charge; and

(b) Whether income generated from A&E service in public hospitals would be used on improving A&E service in public hospitals.

Ms HO hoped that income generated from A&E service in public hospitals would be used on improving A&E service in public hospitals, and not used on helping to eliminate the budget deficit of HA.

22. Director, HA responded that immediate treatment had all along been given to patients arriving at HA's A&E departments in critical conditions, regardless of the introduction of the new A&E charge. As to whether the average waiting time of patients in emergency and urgent conditions at HA's A&E departments had been shortened after the introduction of the new A&E charge, Director, HA said that more time would be needed to compile such information. Director, HA also pointed out that whilst there might not be any significant reduction in the waiting time of patients in emergency and urgent conditions at HA's A&E departments, the quality of services provided in critical, emergency and urgent cases would be improved.

23. Director, HA further said that income generated from A&E service in public hospitals would not necessarily be used on improving A&E service in public hospitals. Similar to other income earned by HA, income generated from A&E service in public hospitals would be used on areas most in need. Director, HA envisaged that there should not be any need to inject more money to improve HA's A&E service, as some of the resources previously spent on semi-urgent and non-urgent cases could now be used on critical, emergency and urgent cases. DSHWF clarified that the revamp of the fees structure of HA, including the introduction of the new A&E charge, was to better target Government subsidy at services most in need and minimise inappropriate use and misuse. There was no question of revamping the fees structure of HA to address the budget deficit of HA, as the revamp of the fees structure of public health care services was an initiative under the Health Care Reform introduced in December 2000 before the deficit problem of HA had arisen.

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24. Dr LAW Chi-kwong noted that from December 2001 to February 2002, the average daily attendance of all HA's A&E departments was 6 659. Meanwhile, the same figure from December 2002 to February 2003, i.e. the first three months after the introduction of the new A&E charge, was only 5 908, representing an overall decrease of 11.3%. In the light of this, Dr LAW asked whether any study had been made to find out where these patients had gone.

25. Director, HA replied in the negative. Nevertheless, to his knowledge, some private medical practitioners had extended their consultation hours after the introduction of the new A&E charge by HA. The Chairman said that to his understanding, there had been no markedly increase in the number of patients seen by private medical practitioners after the introduction of the new A&E charge by HA. Dr LAW Chi-kwong was of the view that in order to fully assess the effect of the new A&E charge in public hospitals, it was necessary to find out where the people, who would ordinarily use HA's A&E service before the introduction of the new A&E charge, had gone to seek treatment after the introduction of the new A&E charge. DSHWF agreed, but pointed out that the success of the study would depend very much on the co-operation of the medical profession and trade.

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26. Mr Fred LI asked whether the manpower of all A&E's departments in public hospitals would be cut, in view of the drop in the number of A&E attendance, to help eliminate the budget deficit of HA. Mr LI further asked whether consideration could be given to waiving the A&E fee of those patients whose injuries were not brought on by themselves, such as if they were harmed by robbers. To better understand the effect of the new A&E charge on the utilisation of A&E service in pubic hospitals, Mr LI requested the Administration to provide a comparison of the A&E attendance by time intervals before and after the introduction of the new A&E charge.

27. Director, HA responded that HA had no plan to adjust the resources for the provision of A&E service in public hospitals. As to Mr LI's second question, Director, HA said that the A&E charge for patients brought in by the Police would be waived of paying the A&E fee. Other than this, it would be very difficult for HA staff to determine whether a patient did suffer injury as a victim. Director, HA undertook to provide the information requested by Mr LI in paragraph 26 above.

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28. In summing up, the Chairman said that the Administration, in assessing the effect of the new A&E charge, should examine how effective it was in diverting patients in semi and non-urgent conditions to use alternative modes of medical services.

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IV. Remodelling of the Tuen Mun Polyclinic Building for the Establishment of an Ophthalmic Centre
(LC Paper No. CB(2)1397/02-03(04))

29. Director, HA took members through the Administration's paper which set the justifications for the remodelling of the Tuen Mun Polyclinic Building (TMPC) for the establishment of an ophthalmic centre. Director, HA further said that it was the Administration's plan to seek the approval of the Finance Committee (FC) of the Legislative Council (LegCo) in May 2003 to fund the project at an estimated cost of about $87 million. Subject to FC's approval, the construction works would commence in late 2003 for completion in early 2005.

30. Dr TANG Siu-tong expressed support for the proposed project, and hoped that the Administration would fully address the concerns raised by members of the Yuen Long District Council about the long commuting distance between Yuen Long and the new ophthalmic centre. Dr TANG then asked about how the site to be vacated by the Yuen Long Yung Fung Shee Ophthalmic Centre (YLYFSOC) would be used.

31. Director, HA assured members that every effort would be made to ensure that the public transport service between Yuen Long and the new ophthalmic centre in Tuen Mun would be enhanced. As to the usage of the site to be vacated by YLYFSOC, Director, HA said that he did not have information on such.

32. Mr Albert HO expressed support for the proposed project and raised the following questions -

(a) What would be the performance targets of the new ophthalmic centre in Tuen Mun, such as the waiting time for patients to see doctors and to undergo operations, and whether a triage system to give priority treatment to critical cases would be adopted; and

(b) Whether patients in critical conditions would be transferred to an ophthalmic centre in another hospital cluster in the event that YLYFSOC could not cope with these cases.

33. Director, HA hoped that the average waiting time for patients to receive treatment at the new ophthalmic centre in Tuen Mun could be cut short by 50% compared with that at YLYFSOC at present. Director, HA further said that patients in urgent need of major eye operations had always been accorded priority for treatment. At present, it was the general practice that patients in urgent need of major eye operations would be transferred to another ophthalmic centre in the New Territories North cluster if YLYFSOC could not perform the operations.

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34. Mr Michael MAK noted that tertiary ophthalmic care in the New Territories West (NTW) cluster and secondary ophthalmic care in Tuen Mun district would in future be provided by the new ophthalmic centre at the TMPC Building, while secondary ophthalmic care in Yuen Long district would be provided by the new eye clinic to be set up at Pok Oi Hospital (POH) upon completion of project 5ME "Redevelopment and Expansion of POH" in end 2006. In the light of this, Mr MAK asked why secondary ophthalmic care in NTW cluster could not be provided centrally by the new eye clinic to be set up at POH. Mr MAK further asked why HA first consulted the Tuen Mun and Yuen Long District Councils before coming to the Panel.

35. Director, HA explained that the site constraint of POH had rendered it not feasible for secondary ophthalmic care in the NTW cluster to be provided solely by the new eye clinic to be set up at POH. Director, HA further said that the arrangements of providing secondary ophthalmic care in Tuen Mun district through the new ophthalmic centre at the TMPC Building and in Yuen Long district through the new eye clinic to be set up at POH was reasonable, having regard to the large geographical spread of NTW cluster. Director, HA also said that providing secondary ophthalmic care in Tuen Mun district was logical, as YLYFSOC was under the management of Tuen Mun Hospital. As to Mr MAK's second question, Director, HA said that HA considered appropriate to first consult the relevant District Councils on the proposed project which would affect the residents in the North West New Territories. HA would, however, consult the Panel first if the matter would affect the whole territory.

V. Report of the Task Force on Population Policy : Provision of Public Health Care Services

(LC Paper No. CB(2)1397/02-03(05))

36. DSHWF briefed members on the Administration's paper which set out the recommendations relating to the provision of public health care services contained in the Report of the Task Force on Population Policy.

37. Dr LAW Chi-kwong queried the justification for subjecting the use of subsidised public health care services to seven-year residence requirement. If that was the case, then non-permanent residents of Hong Kong should also be required to pay full cost for use of many heavily-subsidised public facilities, such as roads. Dr LAW further said that setting seven years as the length of residence required for use of subsidised health care services was too long, and asked the Administration whether it had conducted any study on the length of residence required for use of the same by non-permanent residents in overseas jurisdictions. Dr LAW further asked whether the seven-year residence requirement for use of subsidised health care services would apply to Two Way Permit holders who

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claimed to have right of abode in Hong Kong. Given that children born in Hong Kong to Two Way Permit holders who were spouses of Hong Kong permanent residents were automatically permanent residents of Hong Kong and therefore were entitled to subsidised public health care services, it was arguable whether their mothers should pay the full cost for giving birth to them in public hospitals.

38. DSHWF responded that justification for subjecting the use of subsidised public health care services to seven-year residence requirement or setting seven years as the length of residence required for use of subsidised health care services had been provided by the Chief Secretary for Administration in his announcement of the Report of the Task Force on Population Policy. DSHWF further said that studies had been made on the eligibility for use of subsidised health care services in overseas places, the findings of which all revealed that visitors had to pay the full cost of using public health care services. At present, the heavily subsidised health care services in Hong Kong were available not only to the general population, but also to the transient population, including foreign domestic helpers (FDHs), migrant workers and Two Way Permit holders who were spouses or children of 11 years of age of Hong Kong Identity Card holders. Recognising the considerable impact the seven-year residence requirement would have on a large number of people in Hong Kong, including residents with less than seven years of stay in Hong Kong, One Way Permit holders and migrant workers, the Task Force on Population Policy proposed to initially apply such requirement to Two Way Permit holders and other visitors with effect from 1 April 2003. The Health, Welfare and Food Bureau (HWFB) would conduct an in-depth study to assess the impact of the policy on the rest of the affected population before considering when and how this policy would be applied in the longer term.

39. Dr LAW remarked that there was no dispute that visitors should be required to pay the full cost of using public health care services. Dr LAW, however, pointed out that Mainland spouses of Hong Kong Identity Card holders were forced to visit Hong Kong under the Two Way Permit Scheme while waiting for their turn to settle in Hong Kong under the One Way Permit Scheme operated by the Mainland authorities. Dr LAW suggested and members agreed to request the Research and Library Services Division of LegCo to conduct a research on the policy and eligibility for use of public health care services in other jurisdictions.

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40. Mr Albert HO pointed out that One Way Permit holders could be broadly divided into two groups: children of Hong Kong permanent residents with Certificate of Entitlement; and spouses and other dependents. The former group would become Hong Kong permanent residents when they entered Hong Kong and would entitle to subsidised health care services, whereas the latter group would need to reside in Hong Kong for a continuous period of not less than seven years to become Hong Kong permanent residents to enjoy subsidised health care services. In the light of this, Mr HO queried whether such arrangements would

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be in breach of human rights and the relevant provisions of the Basic Law. In view of the fact that residents with less than seven years of stay would not be entitled to subsidised health care services, Mr HO asked whether consideration could be given to waiving the charges for people who could not afford to pay the full cost of public health care services. Otherwise, it would be ironic for Hong Kong to claim itself a caring society.

41. DSHWF clarified that eligibility for use of subsidised health care services was not based on whether the users had permanent resident status in Hong Kong, but on the length of residence in Hong Kong. According to legal advice, basing eligibility for use of subsidised health care services on length of residence was legally sound. DSHWF reiterated that the Administration had not yet decided on how and when to apply the seven-year residence requirement for use of subsidised health care services to people who were not Hong Kong permanent residents, including residents with less than seven years of stay in Hong Kong and One Way Permit holders.

42. DSHWF further said that the adoption of the new policy would not turn Hong Kong into an uncaring society. Firstly, the objective of the policy was to see that social resources were used on the people of Hong Kong, in particular against the current austere fiscal situation when resources were increasingly limited and demand was continuously rising. Secondly, the Government would continue to uphold its fundamental principle that no one, including visitors, would be denied adequate medical care because of lack of means. Visitors and residents who were not permanent residents of Hong Kong would also be eligible to apply for financial assistance under HA's fee waiver mechanism. Where appropriate, full fee waiver would be granted. Director, HA supplemented that visitors in acute condition would be treated immediately regardless of whether they could afford to pay the full cost for use of public health care services. Responding to Mr Albert HO's enquiry as to whether this meant that HA would not treat visitors who could not pay the full cost for use of public health care services if they were not in acute condition, Director, HA said that this was necessary because public health care resource should as a matter of priority be targetted at Hong Kong people.

43. Referring to the low fertility rate in Hong Kong, Mr Michael MAK asked whether the Administration would adopt pro-natalist policies to promote childbirth. Mr MAK further asked whether good health condition would be one of the eligibility criteria for admission into Hong Kong as capital investment entrants.

44. DSHWF responded that the Task Force on Population Policy had considered whether Hong Kong should adopt pro-natalist policies to promote childbirth. In the final analysis, the Task Force considered it not appropriate to do so, as it was very much a matter of individual choices and the effectiveness of pro-natalist policies to promote childbirth adopted in countries with low fertilities

rates were not clear. The Task Force recommended the following -

(a) To continue with the current family planning programmes emphasising healthy, planned parenthood;

(b) To encourage the Family Planning Association of Hong Kong to change its name to better reflect its present scope of work; and

(c) To consider granting the same level of tax deduction for all children irrespective of number.

DSHWF further said that he did not have the answer to Mr MAK's second question, as details of the eligibility criteria for admission into Hong Kong capital investment entrants had not been drawn up. DSHWF, however, pointed out that investment immigrants would also be subject to the seven-year residence requirement for use of subsidised public health care services.

45. Ms LI Fung-ying asked whether the policy of requiring residents who were not permanent residents of Hong Kong to pay the full cost for use of public health care services would be implemented in phases, and if so, the timetable for the phased implementation. DSHWF responded that no timetable had been set for such, as the complexity of the issue and the large number of people affected necessitated an in-depth study by HWFB. The public and members would be consulted when HWFB had completed its study on the impact of the policy on the affected population before deciding on the way forward.

46. Ms Cyd HO pointed out that the policy of requiring Two Way Permit holders who were spouses of Hong Kong Identity Card holders to pay the full cost for use of public health care services with effect from 1 April 2003 would be in breach of the Sex Discrimination Ordinance (Cap. 480). Noting that the health care costs of FDHs were borne by their employers, Ms HO said that it would be unfair if similar coverage was not provided for Two Way Permit holders who were spouses of Hong Kong Identity Card holders during their stay in Hong Kong.

47. DSHWF clarified that there was no question of the policy being in breach of Cap. 480. It was the established policy that all visitors, including Two Way Permit holders, had to pay the full cost for use of public health care services. The fact that hitherto Two Way Permit holders who were spouses or children under 11 years of age of Hong Kong Identity Card holders were exempted from paying the full cost for use of public health care services was an exception rather than the rule. The new arrangement to take place on 1 April 2003 was thus to remove such anomaly. DSHWF further said that it was not appropriate to put FDHs and Two Way Permit holders who were spouses of Hong Kong Identity Card holders on an equal footing, as the former were migrant workers who had all along been

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provided with free medical treatment by their employers by contract, whereas the latter were essentially visitors. Nevertheless, the Administration would encourage Two Way Permit holders who were spouses of Hong Kong Identity Card holders to purchase medical insurance coverage in the Mainland or in Hong Kong to meet their health care needs during their stay in Hong Kong.

48. Ms Cyd HO disagreed that exempting Two Way Permit holders who were spouses or children under 11 years of age of Hong Kong Identity Card holders from paying the full cost for use of public health care services was giving them preferential treatment and therefore should be removed. Ms HO was of view that they should continue to be exempted from paying the full cost for use of public health care services, having regard to the fact that the reason why they were put in this predicament of uniting with their families under the Two Way Permit Scheme was due to the fault of the Government.

49. Dr LAW Chi-kwong was of the view that all heavily subsidised public services, including public health care services, should adopt the eligibility criteria for subsidised housing. Namely, at least half of the family members included in the application must have lived in Hong Kong for seven years and were still living in Hong Kong. All children under the age of 18, regardless of their place of birth, would be deemed as having satisfied the seven-year residence rule provided that one of their parents had lived in Hong Kong for seven years.

50. Mr Albert HO and Dr YEUNG Sum were of the view that the seven-year residence requirement for use of subsidised health care systems was overly long and would create a heavy financial burden on new arrivals. They were also of the view that new arrivals, who were Mainland spouses and other dependents of Hong Kong Identity Card holders, should not be subject to residence requirement for use of subsidised health care services as they were not immigrants per se. If they had to reside in Hong Kong for a continuous period of not less than seven years in order to be eligible for use of subsidised health care services, ill feeling towards Hong Kong might be engendered by them, which would not be conducive to social cohesion of Hong Kong.

51. DSHWF responded that the Administration would carefully consider members' views on the seven-year residence requirement for use of subsidised health care services. He reiterated that the existing policy of only requiring people who did not hold Hong Kong Identity Cards to pay the full cost for use of public health care services would remain unchanged. The Administration would consult the public and the Panel after it had completed an in-depth study to assess the impact of the seven-year residence requirement for use of subsidised health care services policy before considering when and how this policy would be applied in the longer term.

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VI. Doctors Employed on Contract Terms for Professional Training in the Hospital Authority
(LC Paper No. CB(2)1397/02-03(06))

52. Director, HA introduced the Administration's paper detailing the arrangements for doctors employed on contract terms for professional training in HA.

53. Dr YEUNG Sum urged HA to continue to employ doctors on contract terms until the latter had completed their professional training. Director, HA assured members that this was also the intention of HA. For instance, although the standard supervised training period of doctors on the Resident Training Programme was six years, HA would provide an extra contract year to facilitate suitable trainees of various clinical specialties to complete the required training. Such an arrangement on the duration of training period was implemented after consultation with the Hong Kong Academy of Medicine (the Academy). The extra contract year would be flexibly administered either at the end of the first contract for basic training or at the end of higher training (i.e. after six years' training) to suit individual trainees' progress and the assessment schedules of the Colleges of the Academy. Flexibility to extend the contract period for training of doctors on the Resident Training Programme beyond seven years to meet the examination schedules of the Colleges of the Academy would be considered on a case-by-case basis and on individual merits. Director, HA further said that the reason for recruiting medical officers on contract terms to facilitate the development of a specialist training pathway for various clinical specialties in 1997 were twofold. One was to allow more flexibility for HA to regulate the number of specialists required by each specialty given the unpredictability of turnover in the specialties, the uncertainty of the trainees' success rate in acquiring specialist qualification, and the changes in demand for specialists in respect of a specialty in the light of technological evolution, changes in demographics and disease patterns. The other was to provide adequate training opportunities for new medical graduates.

54. Mr Michael MAK asked the following questions -

(a) Whether nurses and other health care personnel employed on contract terms in HA could stay on after their contracts expired;

(b) Whether any career counselling would be provided to trainees who had completed their specialist training but were not offered a contract to stay on in HA for service delivery; and

(c) Whether the 17 doctors employed on contract terms for service

delivery in HA referred to in paragraph 7 of the Administration's paper possessed the requisite specialist qualifications.

55. Director, HA responded that renewal of contracts of nurses and other health care personnel depended on service needs and their work performance. To alleviate the heavy workload of nursing staff, recruitment of nurses would continue. Similar to the seasons given in paragraph 53 above, employing nurses and other health care personnel on contract terms would also provide HA with the flexibility in regulating the number of health care staff required to meet service needs. Director, HA replied in the positive to Mr MAK's second question. As to Mr MAK's last question, Director, HA said that not all of the 17 doctors employed on contract terms for service delivery in various clinical specialties possessed the requisite specialist qualification. Nevertheless, they all possessed ample experience in their own clinical specialties.

56. The Chairman asked about the number of trainees on the Resident Training Programme who would complete their training and attain the specialist qualification, and how many of them would stay on in HA. The Chairman expressed concern that if HA let all these trainees left HA, there would be not adequate experienced doctors to carry out the Resident Training Programme in the long run. Noting that the contracts of 361 Residents would expire on 30 June 2003, the Chairman further asked how many of them would leave HA then.

57. Director, HA responded that he did not know the number of trainees on the Resident Training Programme who would complete their training and attain the specialist qualification, as the training period of the first batch of trainees had not yet finished. Director, HA further said that to ensure continuity of the Resident Training Programme, HA would offer employment to some trainees who had performed well during their training. As to the Chairman's last question, Senior Executive Manager (Professional Services), HA said that about 40-odd family medicine trainees would leave HA after 30 June 2003 having completed their training. 10-odd Residents would also leave HA after 30 June 2003 because of unsatisfactory performance or slow progress made in obtaining the specialist qualification laid down by the Colleges of the Academy. The Chairman asked whether this meant that a particular Resident would be let go if he could only complete and pass one-half of the number of examinations required to attain the specialist qualification in his fifth year of internship. Director, HA responded that this would depend on whether it was realistic for a particular Resident to complete all the requisite examinations during the remaining time of his training period.

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

Action

Council Business Division 2
Legislative Council Secretariat
10 April 2003