立法會
Legislative Council

LC Paper No. CB(2)2648/02-03

Ref : CB2/PL/HS

Report of the Panel on Health Services
for submission to the Legislative Council

Purpose

This report gives an account of the work of the Panel on Health Services during the 2002-2003 Legislative Council (LegCo) session. It will be tabled at the Council meeting on 2 July 2003 in accordance with Rule 77(14) of the Rules of Procedure.

The Panel

2. The Panel was formed by resolution of this Council on 8 July 1998 and as amended on 20 December 2000 and 9 October 2002 for the purpose of monitoring and examining Government policies and issues of public concern relating to health services matters.

3. The terms of reference of the Panel are in **Appendix I**.

4. The Panel comprises 12 members, with Dr Hon LO Wing-lok and Hon Michael MAK Kwok-fung elected as Chairman and Deputy Chairman of the Panel respectively. The membership list of the Panel is in **Appendix II**.

Major work

Outbreak of Severe Acute Respiratory Syndrome (SARS)

5. Following media reports of an outbreak of atypical pneumonia cases in Guangdong Province in late 2002 and early 2003, the Panel discussed with the Administration in February 2003 the notification mechanism for infectious diseases between Guangdong and Hong Kong and the surveillance system on infectious diseases in Hong Kong. The Administration informed the Panel that the Department of Health (DH) had been in communication with the Mainland

health authorities to understand the latest situation and had also stepped up surveillance on the disease in Hong Kong.

6. Members became very concerned when 43 health care workers in the Prince of Wales Hospital (PWH) contracted respiratory tract infection with pneumonia symptoms within a short period of time in early March 2003. The Panel held a special meeting on 14 March 2003 to discuss with the Administration its handling of the incident. The Administration informed members that upon receipt of the report on the PWH incident from the Hospital Authority (HA) on 10 March 2003, DH had immediately reported the matter to the World Health Organization. The Administration would hold daily press briefings on the latest developments and the public would be alerted if there was any sign of the spread of infection to the community.

7. Since April 2003, the Panel had been monitoring the handling of the SARS outbreak by the Government and HA through its weekly special meetings with the Administration. Members also made use of these meetings to provide feedback from the community on the measures taken by the Administration to control the spread of SARS and their suggestions for improvement. Members were in general supportive of the various measures taken by the Administration to prevent the spread of the disease. However, some members considered that some of the measures had not been implemented as speedily as possible.

8. From the outset, Members had been very concerned about continued infection of health care workers in public hospitals. Of the 1 755 SARS cases in Hong Kong up to 23 June 2003, 386 or 22% involved health care workers of hospitals/clinics and medical students.

9. Noting incessant complaints from the frontline health care workers about insufficient protective gear, in particular N95 face masks, Members pursued the issue of protective gear for frontline health care workers at the weekly special meetings, before the target of zero infection of health care workers was attained. The Administration explained that initially there had been some problems in procurement of protective gear. However, the supply had become steady and adequate, except for small-size N95 face masks, which continued to be in short supply. HA had established a Central Task Force on Supplies and Environmental Control in Hospitals on SARS to monitor stock levels, co-ordinate demands of hospital clusters, secure supplies and ensure effective distribution. It would also define standards and address different levels of needs of the different wards in hospitals. Members urged the HA management, particularly the middle management at the hospital level, to show more understanding of the psychological needs of the frontline health care workers and to provide them with the type of gear which would help them feel assured of being sufficiently protected.

10. Apart from the question of protective gear, Members were also concerned whether frontline health care workers were given sufficient rest to recover from the heavy pressure of work in taking care of SARS patients. Pointing out that health care workers looking after SARS patients on the Mainland were only required to work shifts of four to five hours, some Members suggested that the health care workers concerned in Hong Kong should be required to work shorter shifts. The Administration explained that in addition to one rest day in every period of seven days in accordance with the legal requirements, a special leave of one day in every two weeks would be granted to staff working in SARS areas to relieve the pressure and stress arising from their work. Cluster management was also encouraged to exercise discretion in the arrangement of the special leave over and above the minimum standard, taking into account service demand and intensity of work for individual hospitals and clinical units as well as operational need.

11. Members also expressed concern about the lack of isolation facilities for the control of infectious diseases, which made it difficult to effectively prevent cross-infection of other patients, and infection of health care workers. Members sought information on the negative pressure facilities at public hospitals and noted that continuing improvements to the ventilation and air-conditioning systems of hospital wards would be made. Members urged that isolation wards should be provided in existing hospitals for infection control as soon as possible in case another SARS outbreak should occur later in the year. Some members considered that an infectious disease hospital should be constructed in the long term.

12. The Administration informed the Panel in June 2003 that the Health, Welfare and Food Bureau (HWFB) had set up a Working Group on HA Isolation Facilities under the Inter-departmental Action Co-ordinating Committee on SARS to consider options on how to expand the existing infectious disease control facilities of the public hospital system, and oversee the smooth and timely implementation of feasible projects. The Working Group agreed that as an immediate step, there was a need to improve and develop the existing isolation facilities of all acute hospitals for suspected SARS cases, so that the handling of future SARS cases could be shared among acute hospitals. The option of a centralised temporary isolation facility, which required a large site, would continue to be explored. At the same time, HA had been asked to identify hospitals with readily available sites for building prefabricated construction to provide decentralised isolation facilities at various hospitals.

13. In the light of doubts raised by some overseas experts over the effectiveness of the drugs, Ribavirin and steroids, for treatment of SARS, some Members questioned whether the treatment protocol for SARS patients in Hong

Kong was appropriate. Members also asked whether patients would be given the option of treatment based on Chinese medicine. The Administration explained that as SARS was a new disease, there was no internationally agreed definitive treatment for SARS. Apart from Ribavirin and steroids, other drugs were also used to meet the needs of patients. The attending physicians would decide on the treatment methods to use on specific patients taking into account the known side effects of the drugs, the patient's physical conditions and response to treatment. Alternative treatment options were also being examined with the use of Chinese medicine being one of them. HA had invited two Chinese medicine experts from the Guangdong Provincial Hospital of Chinese Medicine to come to Hong Kong to exchange views with local clinicians on the management of SARS patients in public hospitals using an integrated Chinese and western medicine approach. Chinese medicines would be used to supplement western medicines where appropriate.

14. As many medical experts were of the view that another SARS outbreak could occur later in the year, the Panel had requested the Administration to provide a comprehensive paper on the measures to prepare for possible resurgence of SARS for discussion at the Panel meeting in July 2003.

Proposal for a select committee to inquire into the handling of the SARS outbreak

15. The Panel passed a motion at its meeting on 14 May 2003 proposing that a select committee should be set up by LegCo to inquire into the handling of the outbreak of SARS by the Government and HA and to conduct a comprehensive review of the whole process. Most members considered that even though both the Government and HA would conduct separate reviews of the handling of the outbreak, LegCo should uphold it monitoring role by conducting an independent inquiry into the handling of the outbreak. The Panel's proposal was discussed by the House Committee on 30 May 2003. A motion was passed demanding the Government to appoint an independent Commission of Inquiry in or before October to conduct an investigation into the SARS outbreak and if the Government refused to do so, the House Committee would consider setting up a select committee.

Prevention of spread of SARS among the elderly

16. Members noted that 323 of the 1 755 SARS cases up to 15 June 2003 were aged 65 and above and 186 elderly patients died, most of whom suffered from other chronic illnesses which might have affected their survival rate. Since some elderly SARS patients did not display any symptoms of the disease and had caused infection of health care workers and cross-infection of other patients, Members were concerned whether sufficient work had been done to prevent the spread of SARS among the elderly. As 72 SARS cases had been

reported among residents of 51 RCHEs, of whom 57 died, Members were particularly concerned about frail elders in RCHEs. These elders were a high risk group for SARS as many of them were frequent users of hospital services.

17. The Panel discussed with the Administration in June 2003 the measures to prevent the spread of SARS among the elderly. Members noted that various measures had been taken, including enhanced coverage of HA's Community Geriatric Assessment Teams (CGATs) to RCHEs through collaboration with the Visiting Medical Officers in the private sector to manage episodic illnesses of elderly residents in order to reduce hospital admission, and thereby reducing the risk of exposure to SARS. A member considered that the outreach service should also cover medical follow-ups so that the elderly residents did not have to visit hospitals for that purpose. The member also suggested that in the long term, RCHEs should engage private medical practitioners to provide visiting medical services as there was no way that the CGATs would be able to cover the 700 odd RCHEs.

18. Members were also concerned about the lack of isolation facilities in RCHEs which might lead to cross-infection when elderly residents returned to the RCHEs after hospitalisation. The Administration pointed out that to prevent cross-infection, the Social Welfare Department (SWD) required RCHEs to make "cohorting" arrangements for residents discharged from hospitals. For those RCHEs with difficulty in implementing isolation measures, the Medical Social Workers (MSWs) would work out alternative placements in consultation with relatives. For hospitalised elders from private homes with poor isolation facilities, HA would continue to make necessary arrangements to enable the elders concerned to stay in hospitals for a longer time to ensure that there would be an adequate period of careful observation prior to discharge.

Notification mechanism for infectious diseases between Guangdong and Hong Kong

19. Ever since the first discussion on the SARS outbreak referred to in paragraph 5 above, members had been pursuing the question as to whether there was an effective mechanism between Guangdong Province and Hong Kong for notification of infectious diseases. Members had time and again emphasised the importance of an effective mechanism, given the large number of people crossing the border daily, and had been pressing the Administration to provide more details on the mechanism. On 23 April 2003, the Administration informed the Panel that experts from Guangdong and Hong Kong held the first meeting of the Expert Group on Prevention and Treatment of Atypical Pneumonia in Guangzhou on 17 and 18 April. The two sides agreed on periodic notification on the latest situation on infectious atypical pneumonia as well as setting up a point-to-point exchange mechanism to enhance

communication and to draw on each other's experience in disease control. Both sides also agreed to enhance the existing scope of information exchange by expanding the list of notifiable diseases to cover cholera, dengue fever, malaria, influenza and tuberculosis.

20. At the meeting on 12 June 2003, a Member tabled extracts from an investigation report on atypical pneumonia issued by the health authorities in Guangdong Province on 23 January 2003 which provided valuable information on treatment and prevention of the disease. The Administration admitted that such information had not been provided to Hong Kong, even though DH had tried to obtain more information by writing to the Guangdong health authorities after the latter had announced to the media that there was an outbreak of atypical pneumonia cases in Guangdong with 305 people having been infected and five deaths.

21. Following media reports of cases of encephalitis B in Meizhou in Guangdong Province, the Panel sought information from the Administration on whether there was notification of the disease. According to the Administration, encephalitis B, also known as Japanese encephalitis, was an endemic disease occurring mainly in rural areas and was not in the agreed list of notifiable diseases, and whether it should be notified would depend on the seriousness of the outbreak. In the present case, subsequent to media reports, the Guangdong health authorities had provided information on the situation in Meizhou and daily updates in response to enquiries made by DH. The Administration agreed that there was room for improvement in the notification mechanism and would discuss the issue in more detail with the Guangdong health authorities when the two sides met for the third time in coming August. A member suggested that DH should make public details of its request for information as well as the response so that the public would be aware of the information provided. Another member considered that the matter should be brought to the attention of the leaders in Beijing in order to ensure that the notification system was working effectively.

Restructuring of fees and charges for public health care services

22. The Panel discussed the restructuring of fees and charges for public hospital services and the fee waiver mechanism at the meetings in November and December 2002.

23. Some members expressed support for revamping the fee structure to target public resources to patients most in need, which was integral to ensuring the long term sustainability of the public health care system. Members took the opportunity to enquire about the present position of the proposal to introduce a Health Protection Accounts Scheme. The Administration had responded that it was examining the feasibility of a medical savings scheme to ensure the long

term financial sustainability of the public health care system, and should be in a position to report to members on the outcome in the latter half of 2003.

24. Some members opined that given the current economic downturn, the introduction of the new $100 charge for accident and emergency (A&E) service should be postponed from 29 November 2002 to 1 April 2003 when the new medical fee assistance scheme would come into operation. The Administration did not consider postponement necessary, as the fee should be generally affordable and the existing fee waiver system was adequate to help patients who could not afford it. Comprehensive Social Security Assistance (CSSA) recipients would continue to be exempted from the fee. Moreover, not everyone would need to use A&E service, which was meant for patients in emergency and life-threatening conditions.

25. A member pointed out that no matter how much effort was made to apprise non-CSSA elders of the fee waiver system, some of them would still refrain from using the A&E service after a charge was introduced. The member suggested that patients aged 65 and above should be exempted from paying the A&E fee. The Administration pointed out that the suggestion went against the principle that assistance should only be targeted at those in need and not those who could afford such a fee. The Administration assured members that the proposed enhanced fee waiver system to be introduced would ensure that the fee revision would not impact disproportionately on low income groups.

26. In February 2003, the Panel discussed the enhanced medical fee waiver system to be introduced in parallel with the revised fee structure and 14 organisations were invited to present their views.

27. Some members expressed the view that the eligibility and assessment criteria under the enhanced fee waiver system were far from clear and transparent, as much was left to the discretion of MSWs. The Administration explained that it was necessary for MSWs to have discretion in considering the varied circumstances of the applicants. Review on the effectiveness of the enhanced mechanism in assisting patients in need would be conducted in the light of operational experience and where justified, changes would be made.

28. A member considered merely raising the asset limit for the elderly to $80,000 was not enough, as most elderly patients had no income and had to rely on their savings and suggested that all elderly should be granted full waiver of medical fees. Some members suggested that all elderly aged 65 and above should be granted half fee waiver on production of their Identity Cards in order to save administrative costs and prevent the elderly from delay in seeking treatment. The Administration pointed out that it was not feasible or fair to do so. It was a fact that many well-off elderly patients were users of hospital and rehabilitation services provided by HA and they were well able to afford the

fees in question. The Administration would consider further raising the asset limit and extending the validity period of the waiver for the elderly, particularly those without the support of family members, after the enhanced fee waiver system had been in operation for some time.

Liver transplant arrangements of HA

29. In the light of the advice of a panel of international experts and a local panel, HA decided in January 2003 to accept the recommendations of the panels and to centralise liver transplant operations in the Queen Mary Hospital (QMH). In taking forward the recommendations, HA would establish a central registry for liver transplantation and merge the two liver transplant centres.

30. In the wake of the decision, a professor at PWH and a liver patient organisation lodged complaints with the Complaints Division of LegCo. The policy issues of the complaints were followed up by the Panel at its meeting on 21 January 2003. Members noted that the hospital management of QMH and PWH and the Faculty of Medicine of both the University of Hong Kong and the Chinese University of Hong Kong were supportive of the decision. While all members supported the establishment of a central registry for liver transplants, most members shared the view that there should be two liver transplant centres in Hong Kong.

31. Some members questioned the rationale for designating only one centre in Hong Kong with a population of about seven million and 10% of them being hepatitis B carriers. They were also concerned whether the merged centre would be able to maintain the existing capacity of 80 operations a year and how HA would safeguard the interest of the liver patients of PWH after the merger. Some members queried why HA had not consulted the clinical staff and liver patients of PWH before deciding on the merger. They considered that the merger should be put on hold until the community as a whole had thoroughly discussed the issue.

32. HA pointed out that liver transplantation was a highly specialised field in surgery and in general, the more the number of operations performed by the teams of specialists in a transplant centre, the better the outcome of the transplant operations. QMH was the designated liver transplant centre in HA and was provided with additional resources for each liver transplant operation. Although PWH had been performing liver transplant operations on its own initiative, any further increase in the number of such operations in PWH would cause significant strain to the clinical staff and other essential services. The percentage of hepatitis B carriers in the population should continue to decline because newborn babies and young children up to the age of five were now provided with free vaccinations against the disease. HA assured members that it would ensure that appropriate administrative and clinical arrangements were

in place before the merger was implemented and that the existing capacity to perform liver transplant operations would be maintained after the merger.

33. At the end of the discussion, the Panel passed a motion urging HA to freeze the decision to close the liver transplant centre at PWH with immediate effect and to implement the arrangement of "one registry, two transplant centres" as soon as practicable.

Regulation of health claims

34. The Panel discussed the Administration's proposal to amend the Undesirable Medical Advertisements Ordinance (UMAO) (Cap. 231) for the purpose of regulating health claims. The Administration proposed to include in the UMAO a list of prohibited claims to address the misleading information and exaggerated claims of orally consumed products. Views from the experts and the community would be sought through consultation in finalising/revising the list of prohibited claims.

35. Members noted that the purpose of the prohibition was to prevent improper self-medication by members of the public and the proposal was open on whether exaggerated or misleading health claims which had relatively lower health risk, such as weight reduction and detoxification, should be regulated. A member opined that in order not to undermine freedom of choice of consumers, regulation of health claims should not be too stringent as long as such claims would not cause harm to health. Another member considered that the law should not prohibit exaggerated claims as long as they were not totally unfounded, as exaggeration was a special characteristic of advertisement.

36. Some members expressed concern that the proposed regulation of health claims, in particular those made orally, would be difficult to enforce. Although a health claim made orally would usually come with a leaflet stating the health effects of the product, very often the seller exaggerated the claims orally. The Administration agreed to consider this point when drafting the legislation on regulation of health claims. The Administration would consult the Panel again after it had completed the public consultation on the proposal.

Regulation of medical devices

37. To safeguard public health, the Administration proposed to establish a mandatory system of control over the supply and use of medical devices in Hong Kong. The Panel discussed the proposed control arrangements in May 2003.

38. Members were concerned whether there would be problems in the implementation of the proposed control arrangements, as it was difficult to

prove that the use of certain medical devices in beauty parlours was for medical treatment. The Administration agreed that it was important to define clearly what constituted the use of a medical device for beauty therapy or for medical treatment. Particular attention would be paid to the use of devices such as medical lasers which could have serious adverse effect.

39. Referring to the proposal of limiting the use of high risk medical devices to trained personnel, a Member queried how the Administration could ensure the standard of trained personnel of beauty parlours when there was no registration system for beauty parlours or beauticians. The Member considered that there was a need to impose control over beauty parlours in order to protect consumers' interests. He suggested that HWFB should examine and tackle the issue of regulation of beauty parlours in collaboration with other relevant bureaux. The Administration agreed to further study the issue.

40. A member asked the Administration whether it had made an assessment of the impact of the proposed arrangements on the people in the beauty parlour business. The Administration explained that it was also concerned about the impact and did not want to see many people losing their jobs as a result of over stringent control. For this reason, consideration was being given to allowing non-medical professionals to operate low risk medical devices.

Other matters discussed

41. Other subject matters discussed by the Panel included the development of regulatory standards for Hong Kong Chinese medicinal herbs, provision of Chinese medicine service in the public sector, progress of the registration of Chinese medicine practitioners in Hong Kong, Patients' Choice Item Pilot Scheme, progress of the Working Group on Public/Private Interface, doctors employed on contract terms for professional training in HA, report on the Oral Health Survey 2001, and the parenting programme of DH. The Panel was consulted on the remodelling of the Tuen Mun Polyclinic Building for the establishment of an ophthalmic centre, the redevelopment of staff quarters for the establishment of a rehabilitation block at the Tuen Mun Hospital and the redevelopment of Caritas Medical Centre, Phase 2.

Meetings held

42. From October 2002 to June 2003, the Panel held a total of 27 meetings, one of which was a joint meeting with the Panel on Environmental Hygiene and Food Safety.

Council Business Division 2
Legislative Council Secretariat
27 June 2003

Appendix I

Panel on Health Services

Terms of Reference

1. To monitor and examine Government policies and issues of public concern relating to medical and health services.

2. To provide a forum for the exchange and dissemination of views on the above policy matters.

3. To receive briefings and to formulate views on any major legislative or financial proposals in respect of the above policy areas prior to their formal introduction to the Council or Finance Committee.

4. To monitor and examine, to the extent it considers necessary, the above policy matters referred to it by a member of the Panel or by the House Committee.

5. To make reports to the Council or to the House Committee as required by the Rules of Procedure.

Appendix II

Panel on Health Services

Membership list

Chairman	Dr Hon LO Wing-lok, JP
Deputy Chairman	Hon Michael MAK Kwok-fung
Members	Hon Cyd HO Sau-lan Hon Albert HO Chun-yan Hon CHAN Kwok-keung, JP 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 (Total : 12 Members)
Clerk	Ms Doris CHAN
Legal Adviser	Miss Monna LAI
Date	1 July 2003