立法會
Legislative Council

LC Paper No. CB(2)1171/03-04
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 8 December 2003 at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Hon Michael MAK Kwok-fung (Chairman) Dr Hon LO Wing-lok, JP (Deputy Chairman) Dr Hon David CHU Yu-lin, JP Hon CHAN Yuen-han, JP Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP Hon Jasper TSANG Yok-sing, GBS, JP Hon Andrew CHENG Kar-foo Dr Hon TANG Siu-tong, JP Hon LI Fung-ying, JP
Members absent	:	Hon Cyd HO Sau-lan Hon CHAN Kwok-keung, JP Dr Hon YEUNG Sum Dr Hon LAW Chi-kwong, JP
Members attending	:	Hon Fred LI Wah-ming, JP Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP
Public Officers attending	:	All items Mr Thomas YIU, JP Deputy Secretary for Health, Welfare and Food

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

Miss Noel TSANG
Assistant Secretary for Health, Welfare and Food

Item IV

Dr T H LEUNG
Deputy Director of Health

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

Dr Constance CHAN
Assistant Director (Traditional Chinese Medicine)
Department of Health

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

Item V

Dr T H LEUNG
Deputy Director of Health

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

Dr Cindy LAI
Assistant Director (Special Health Services)
Department of Health

Mr Anthony CHAN
Chief Pharmacist, Department of Health

Mr Tony CHAN
Assistant Secretary for Health, Welfare and Food

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Item VI

Dr T H LEUNG
Deputy Director of Health

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

Dr Cindy LAI
Assistant Director (Special Health Services)
Department of Health

Item VII

Mr. YUE Chi-hang, JP
Director of Architectural Services

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

Mr David TONG Sek-por
Chief Architect/4, Architectural Services Department

Clerk in attendance : Miss Mary SO
Chief Council Secretary (2) 4

Staff in attendance : Ms Amy LEE
Senior Council Secretary (2) 8

I. Confirmation of minutes
(LC Paper No. CB(2)523/03-04)

The minutes of the meeting held on 10 November 2003 were confirmed.

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II. Items for discussion at the next meeting
(LC Paper Nos. CB(2)524/03-04(01) to (03))

2. Members agreed to hold the next regular meeting, originally scheduled for 12 January 2004, to 5 January 2004 at 8:30 am in consideration that a number of members had to attend the full-day meeting of the Select Committee to inquire into the handling of the Severe Acute Respiratory Syndrome (SARS) outbreak by the Government and the Hospital Authority (HA) on 12 January 2004.

3. Members further agreed to discuss the following items in January 2004 -

(a) Centre for Health Protection;

(b) Liver Transplant Arrangement of the Hospital Authority; and

(c) Consultation Paper on Enduring Powers of Attorney.

III. Proposal to undertake an overseas duty visit
(LC Paper No. CB(2)524/03-04(04))

4. Members agreed to conduct an overseas duty visit in early April 2004 to gain a better insight into the functions and operation of the Health Protection Agency in the United Kingdom. The Secretariat would proceed with the preparatory work and consult the Panel on further progress as appropriate.

IV. Progress on the Registration of Chinese Medicine Practitioners, Regulation of Proprietary Chinese Medicines and Provision of Chinese Medicine Service in the Public Sector in Hong Kong
(LC Paper Nos. CB(2)524/03-04(05) and CB(2)573/03-04(03))

5. Deputy Director of Health (DDH) briefed members on the latest developments in the registration of Chinese medicine practitioners (CMPs) and regulation of proprietary Chinese medicines (PMC), details of which were set out in paragraphs 2 to 7 and in paragraphs 8 to 15 of LC Paper No. CB(2)524/03-04(05) respectively. Director (Professional Services and Public Affairs), Hospital Authority (Director HA) followed to brief members on the latest developments in the provision of Chinese medicine (CM) service in the public sector, details of which were set out in paragraphs 16 to 20 of the same paper.

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Provision of CM service in the public sector

Fees and charges

6. Dr LO Wing-lok asked whether free CM services would continue to be provided by the Tung Wah Group of Hospitals (TWGHs), as a result of the CM clinic at Tung Wah Hospital (TWH) joining HA on 1 December 2003.

7. Director HA responded that to his understanding, free CM services would continue to be provided by TWGHs. Director HA pointed out that two different types of CM clinic were established and operated by TWGHs for providing different types of CM service. Notably, CM clinics providing free CM service were catered for the treatment of common ailments, whereas the CM clinics at TWH (operated by TWGHs until 30 November 2003) and Kwong Wah Hospital (KWH) were catered for the development of a research-oriented and evidence-based CM service. The CM clinic at TWH collaborated with the University of Hong Kong and the CM clinic at KWH with The Chinese University of Hong Kong. Unlike the general CM clinics, patients were charged for using the CM clinic at TWH and KWH.

8. Director, HA further said that the purposes of providing CM service in the public sector were to promote the development of evidence-based CM practice through clinical research; to systematise the knowledge base of CM; to develop standards in CM practice; to develop models of interface between western and Chinese medicine; to provide training in evidence-based CM; and to integrate CM into the whole health care system. As primary care was one of the strengths of CM, it was decided, as the first step, to provide outpatient CM service in the public sector. To this end, HA was commissioned to develop a collaborative model of service delivery with those non-governmental organisations (NGOs) with ample experience with providing CM service as well as tertiary institutions having established capacity in research and training. The joining of the CM clinic at TWH with HA was based on such a tripartite model. Director, HA however stressed that the provision of outpatient CM service in the public sector would only be on a limited scale, to avoid competing with the private sector which already provided generally comprehensive and affordable CM services to the community.

9. Dr LO further asked the following questions -

(a) Whether the charging of a fee of $120 per attendance (including consultation and two prescriptions) was applicable to all patients, including those selected to join research-oriented programmes; and

(b) Whether patients would be charged for items such as laboratory test, in addition to the $120 per attendance.

10. Director HA replied in the positive to Dr LO's first question. As to Dr LO's second question, Director HA said that patients would be charged an additional fee if they required more than two prescriptions or requested the CM clinic to boil the Chinese medicinal herbs on their behalf. Regarding fee for laboratory test, Director HA said that patients selected to join research-oriented programmes would generally not be charged such fee. Director HA pointed out that there were views from some quarters in the community that patients selected to join the research-oriented programmes should be waived of paying any fee. As for patients considered not suitable for joining the research-oriented programmes, Director, HA said that the chance of them requiring to undergo laboratory test should be minimal. However, HA would not rule out charging this group of patients for laboratory test where justified.

11. Mr Andrew CHENG said that the charge of $120 per attendance was too high, having regard to the fact that private providers of CM generally charged $80 to $100 per attendance, including two prescriptions. In the light of this, Mr CHENG asked whether consideration could be given to lowering the $120 fee after the setting up of the planned 18 CM clinics in the public sector. Mr CHENG further asked what the estimated sum for providing CM service in the public sector was and the level of subsidy to such provision. Mr CHENG pointed out that he had raised the same questions during the meeting of the Panel held on 10 February 2003 when the issue of the provision of CM service in the public sector was first discussed, but responses to them were still outstanding.

12. Director HA responded that the level of subsidy to outpatient CM service was around 50%, given that the cost per attendance was about $240. This had already based on the assumption that all 18 planned CM clinics in the public sector were set up. Director HA further said that the high cost of the CM clinic under HA was due to the inclusion of research element, which was generally not present in the private solo practice and CM clinics operated by NGOs. Cases in point were that an information technology system, containing comprehensive functions covering areas like registration and appointment, payment, clinical management, pharmacy function and medical records, had been developed to serve all CM clinics under HA for the development of evidence-based CM and clinical research and development. A Toxicology Reference Laboratory had been set up at Princess Margaret Hospital to analyse clinical specimen for toxicity of CM and to build up a database to support the overall development of an evidence-based CM service.

13. Deputy Secretary for Health, Welfare and Food (DSHWF) supplemented

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that the questions raised by Mr CHENG in paragraph 11 above had been answered by the Administration at the meeting of the Panel on 10 February 2003. He would be happy to provide the information again if needed. DSHWF further said that it was not the Administration's intention to compete with the private CM providers for the provision of primary care. It was envisaged that the public sector would only take up about 5% of the CM service market when all the 18 outpatient CM clinics under HA were set up.

14. Dr LO Wing-lok sought clarification from the Administration as to whether the level of subsidy to CM service not having a research element would be less than 50%. It was mentioned by the Administration at the meeting of the Panel on 10 February 2003 that the level of subsidy to CM service was 37%, given that the cost per attendance was $190 if the element of research was excluded. Director, HA replied in the positive to Dr LO's question.

15. Mr Andrew CHENG suggested to set aside, say, half of the 18 planned CM clinics under HA to provide research-based CM service, with the remaining clinics catered for the provision of general CM service. In so doing, patients who chose to attend the research-based CM clinics would be charged a fee of $120 per attendance, whilst those who chose to attend the general CM clinics would be charged a lower fee. Mr CHENG hoped that the Administration would consider such a suggestion, in consideration of the fact that many elders, who had limited or no income, much preferred CM treatment and that the population of Hong Kong was ageing.

16. Director, HA responded that patients seeking CM treatment could choose between general CM service provided free of charge by clinics operated by TWGHs located nearby TWH and KWH and the fee-charging research-based CM clinics at TWH under HA and at KWH. Nevertheless, the Administration and HA would take into account Mr CHENG's suggestion in paragraph 15 above, in its review of the operation of the three CM clinics set up in 2003. DSHWF reiterated that it was not the Administration's intention to compete with the private CM providers for the provision of primary care through the introduction of CM service in the public sector, as there was already a private market providing generally comprehensive and affordable CM services to the community. DSHWF further said that such an approach was in line with the Government's policy in the provision of primary care in western medicine, as evidenced by the fact that over 80% of primary care in Hong Kong was provided by private western medicine practitioners.

17. Dr TANG Siu-tong said that if the research-based CM clinics were treated as special outpatient (SOP) clinics, he would consider the charge of $120 per attendance reasonable. However, if the clinics were essentially for conducting

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clinical research, patients selected to join research oriented programmes should be waived of paying any fee.

18. Director HA responded that it was very difficult to position research-based CM clinics under HA as SOP clinics, as unlike in the western medicine which had structured training programmes for different specialisations, this had not yet happened in CM. In spite of its long history, the practice and toxicology of CM lacked a strong scientific basis of evaluating clinical efficacy. Moreover, little efforts had been made to promote clinical research and to develop standards of practice. Director HA however pointed out that the research-based CM clinics were to some extent likened to SOP clinics in the sense that patients referred by western medicine practitioners might in turn be selected to join research projects developed with reference to the prevailing diseases specific to the demographic profile of the population and for which treatment by CM was considered to be beneficial. Director HA further said that patients considered not suitable for joining the research oriented programmes would be provided with appropriate management of their presenting condition on a one-off basis.

19. Dr TANG Siu-tong commented that patients seeking CM treatment for common ailments might not be able to differentiate between a general CM clinic and a research-based CM clinics. In response, Director HA said that efforts would be made to educate the public on the background and need for introducing CM clinics in the public sector and the justification for charging a fee of $120 per attendance.

20. Mr Andrew CHENG said that the above discussion on fees and charges for CM service in the public sector reaffirmed his belief that two types of charges should be provided, given the differences in the cost and level of subsidy to services with and without a research element.

21. Director HA responded that it was very difficult to delineate the service of CM clinic in the public sector along the line suggested by Mr CHENG in paragraph 20 above, as the condition of patients could change over time. Nevertheless, the cost per attendance and level of subsidy, amongst others, would be reviewed in light of the operational experience of the first three CM clinics set up in 2003.

Recruitment of CMPs

22. Responding to Dr TANG Siu-tong's enquiry as to whether CM clinics in the public sector would consider recruiting local CM graduates, Director HA said that both local CM graduates and CMPs would be considered. Director HA however pointed out that as the main objective of the CM clinics in the public sector was to

develop a research-oriented and evidence-based CM service, there was no ruling out of hiring CMPs from outside Hong Kong who had experience in this area.

23. Dr TANG further asked the following questions -

(a) Whether CMPs recruited from outside Hong Kong to work at the CM clinics under HA would be allowed to treat patients; if so, what the arrangements were; and

(b) Whether the use of the tripartite model for introducing CM service in the public sector was aimed at developing an integrated approach of using western and Chinese medicine in treating patients.

24. Director HA replied in the positive to Dr TANG's question, if CMPs recruited from outside Hong Kong could obtain a certificate of limited registration from the Chinese Medicine Practitioners Board of the Chinese Medicine Council of Hong Kong (PB). Director HA pointed out that under section 83 of the Chinese Medicine Ordinance, an educational or scientific research institution might apply to PB for limited registration on behalf of a person, who was not a registered CMP registered by PB or who had a qualification that qualified him to apply to be registered but it was impracticable for him to obtain registration in the circumstances, to whom it wished to employ to enable him to perform predominately clinical teaching or research in CM. HA was one of the six institutions specified by PB in the Gazette, which might apply for limited registration as specified by PB. Under section 86 of the Ordinance, validity period of the limited registration approved by PB did not exceed one year. The person with limited registration could only perform the specified clinical teaching or research in the named employing institution. Such an arrangement was similar to that practised by the Medical Council of Hong Kong. DDH supplemented that PB would not prohibit a person with limited registration to treat patients, as it was understood that clinical research would inevitably involve the treatment of patients. DDH added that as at 8 December 2003, about 50 persons were working in various educational or scientific research institutions in Hong Kong with limited registration.

25. As to Dr TANG's second question, Director HA responded that it was too early to tell at this stage when; and if so, the types of interface between western and Chinese medicine which HA would adopt in treating patients. As a start, focus would be centred on meeting the objectives mentioned in paragraph 8 above.

Timetable for setting up the 18 planned CM clinics in the public sector

26. Responding to the Chairman's enquiry as to whether the planned 18 clinics

would be set up before 2005 as pledged by the Chief Executive (CE) in his 2001/2002 Policy Address, Director HA said that it was unlikely that such a target could be met. This had been reported to CE at the beginning of the year, and endorsed by the Executive Council that the first step was to set up three clinics to provide CM outpatient service in 2003. The schedule for the establishment of the rest of the clinics would be reviewed in light of the operational experience and the budgetary situation.

Manpower requirement

27. Responding to the Chairman's enquiry on the manpower requirement for the provision of CM service in the public sector, Director HA said that HA did not envisage any difficulty in this regard as the new service of delivery would be taken forward in a paced and progressive manner.

Registration of CMPs

28. Ms LI Fung-ying expressed concern over the low passing rate of 47% of the first CMP Licensing Examination Part I Written Examination held in August 2003. Ms LI asked whether any assistance had been or would be provided by the Administration to help those candidates who failed the written examination, such as organising refresher courses. Ms LI further asked when the draft professional guide on issuing sick leave certificates for reference of registered CMPs would be ready for use and the types of guidance to be provided.

29. DDH responded that the passing rate of 47% of the first CMP Licensing Examination Part I Written Examination held in August 2003 could not said to be low. To his understanding, it was higher than the overall passing rates of many health care professional written examinations. DDH further said that there was no need for the Administration or PB to organise refresher courses to help candidates to better prepare for the written examination, as many organisations had been offering such courses. DDH pointed out that there was no cause for concern that the livelihood of people would be affected by their failure in the written examination, as they could still practise CM as listed CMPs. According to the Chinese Medicine Ordinance, the Secretary for Health, Welfare and Food (SHWF) was empowered to specify and promulgate the cut-off date of the transitional arrangement for CMPs by notice in the Gazette. After that date, only registered CMPs would be permitted to practise CM in Hong Kong. As mentioned at the meeting of the Panel on 12 May 2003, SHWF would take into account factors in the public interest, including the latest development of CMPs at that time, and the views of the community before deciding on the schedule for putting an end to the transitional arrangement.

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30. As regards the professional guide on issuing sick leave certificate, DDH said that the guide would be ready in one to two months' time. The finalised guide would be issued to all registered CMPs and uploaded onto the relevant Web Site(s), after the introduction of legislative amendments into the Legislative Council (LegCo) to recognise sick leave certified by CMPs under labour legislation. DDH further said that the guide would set out, amongst others, the recommended sick leave for a list of common ailments and whether any follow-up consultation would be required.

31. Ms LI Fung-ying wondered whether public health would be undermined by allowing practising CMPs, who failed the written examination, to continue practising CM. Ms LI then asked about the main reason accounting for the failure to pass the written examination.

32. DDH responded that the main reason attributing to the failure of practising CMPs to pass the written examination was because many candidates were not familiar with answering multiple-choice questions which the written examination wholly consisted. To address the problem, the Administration would liaise with PB on ways to helping candidates to improve their examination skills. DDH further said that there was no cause for concern that public health would be undermined by allowing practising CMPs who failed to pass the written examination to continue practising CM, as the main reason for them failing to pass the written examination was not due to their lack of knowledge of CM. This was evidenced by the fact that candidates who passed the Part I Written Examination had attained a very high passing rate of 82% in the Part II Clinical Examination held in September to October 2003.

33. Dr LO Wing-lok asked whether the nature of the advisory letter issued by the Disciplinary Committee of the Chinese Medicine Practitioners was similar to that of the warning letter issued by the Medical Council of Hong Kong which was of a disciplinary nature.

34. DDH responded that the advisory letter was not disciplinary in nature. DDH pointed out that the majority of the cases handled by the Disciplinary Committee of the Chinese Medicine Practitioners were about advertising and canvassing. This was understandable, as practising CMPs needed time to familiarise themselves with the new Code of Practice introduced by PB for registered and listed CMPs. With continual actions taken to educating CMPs on the Code of Practice, the number of advisory letters to CMPs had been reduced from 97 (eight cases dismissed) in 2002 to 34 (with 25 cases dismissed) from January to June 2003. DDH however pointed out that if a registered or listed CMP was alleged to be guilty of misconduct in any professional respect a second time after the issuance of the advisory letter or had been convicted of any offence

punishable with imprisonment, PB might hold inquiry and take disciplinary action against the registered or listed CMP concerned. Disciplinary actions might include removing of the name of the practitioner concerned from the Register of Registered Chinese Medicine Practitioners or from the list of listed CMPs maintained by the Board, reprimanding the practitioner or issuing of a warning letter to the practitioner.

Registration of PCM

35. Dr LO Wing-lok asked whether the Administration had fully addressed the concerns raised by the trade concerning the registration of PCM, as provided for under the commencement notices of the relevant provisions of the Chinese Medicine Ordinance, the Chinese Medicines Regulation and the Chinese Medicine (Fees) Regulation published in the Gazette on 24 October 2003. Dr LO expressed support for the coming into effect of the aforesaid subsidiary legislation on 19 December 2003, and asked if members were supportive of the same.

36. DDH responded that the Administration had conducted extensive consultation with the trade on the registration scheme for PCM during the past two years. To his understanding, about 99% of the Chinese medicines traders were supportive of the registration of all PCM manufactured or sold in Hong Kong to be commenced on 19 December 2003.

37. Members did not raise any objection to the commencement of the registration of PCM on 19 December 2003.

V. Regulation of health claims

(LC Paper Nos. CB(2)509/03-04(01), CB(2)524/03-04(06) to (07) and CB(2)573/03-04(01) to (02))

38. DDH took members through the Administration's paper (LC Paper No. CB(2)524/03-04(06) which set out the progress made in the proposal for regulation of exaggerated and undesirable health claims.

39. Mr Fred LI said that the Democratic Party was in support of tightening control of food products claiming misleading or exaggerated beneficial health effects. Mr LI however pointed out that using the Undesirable Medical Advertisements Ordinance (UMAO) to regulate the claims of products generally described as "health food" was patently wrong, having regard to the fact that these products did not contain any medicine. If that was the case, they should have already been regulated under the Pharmacy and Poisons Ordinance or the Chinese Medicine Ordinance. In his view, the Administration should formulate a new

piece of legislation to regulate misleading or exaggerated claims of health food products, as had been done in some overseas jurisdictions. Mr LI then asked whether the proposed revised framework of regulation of health claims, as set out in paragraph 11 of the Administration's paper, would restrict or prohibit such exaggerated claims of orally consumed products such as de-ageing. Mr LI was of the view that a better approach was to require all health food products to undergo testing to substantiate their claims before they could be offered for sale in Hong Kong.

40. DDH responded that there was no plan to regulate exaggerated claims, such as de-aging, and which would not carry high public health risk for the time being, as the purpose of the regulation of health claims was to prohibit improper self-medication by members of the public, thereby causing them harm as a result of either improper self-medication itself, or the delayed proper treatment they should receive. To this end, a risk-based approach was proposed to be adopted to prohibit or restrict specified claims. Notably, the first level of restriction would apply to the most risky claims, namely, the claims relating to the prevention, elimination or treatment of breast lumps, regulation of the endocrine system and regulation of the function of the genitourinary system. The making of such claims would not be allowed under any circumstances. For the second level of restriction relating to the regulation of blood sugar, blood pressure, blood lipids or cholesterol and alteration of the functions of the pancreas, manufacturers or traders could make only the permissible claims as directed by the Director of Health. For instance the claim "Suitable for people concerned about blood sugar" would be allowed, provided that if the product was not registered under the Pharmacy and Poisons Ordinance or the Chinese Medicine Ordinance, and that both the product label and the advertisement clearly included a disclaimer that "This is not a registered pharmaceutical product or a registered proprietary Chinese medicine". For claims subject to the third level of restriction, namely those related to the regulation of immune system, detoxification and slimming, they could be allowed if made in a very general sense without reference to improvements to any specific body functions and that both the product label and the advertisement clearly included a disclaimer identical to that required under the second level of restriction.

41. As regards the suggestion of introducing a pre-market approval mechanism, DDH said that this would need extensive consultation to reach decisions acceptable to the manufacturers, traders and the public. In view of the time and cost involved for a health food product to undergo pre-market testing, due consideration needed to be made on its impact on the health food industry. DDH further said that the aim of UMAO was to protect public health and not to ensure the efficacy of a certain product. For instance, a product claiming that it could treat cancer would be prohibited regardless of whether such a claim was genuine.

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This was to avoid improper self-medication and delayed proper treatment.

42. DSHWF supplemented that formulating a new piece of legislation to regulate misleading or exaggerated claims made by health food products which did not have high public health risk needed to be examined carefully by the community as a whole, to avoid the problem of over-regulation and undermining the freedom of choice of consumers.

43. Mrs Selina CHOW said that the health food industry welcomed the Administration's move to make the regulation of health claims less stringent than the original proposal as set out in paragraph 3 of the Administration's paper. Nevertheless, the industry considered it inappropriate to use UAMO to regulate health food products as these products did not contain any medicine. Mrs CHOW hoped that the intention of the regulation of health claims was not to ensure the efficacy of the claims, but to protect consumers from misleading information and exaggerated claims. If the former was true, it would create much public anxiety if similar thinking would extend to cover products such as cosmetic and home appliances. Mrs CHOW was of the view that the law should not prohibit exaggerated claims so long as the claims were not completely unfounded, as exaggeration was a special characteristic of advertisement. In regulating health claims, due regard should be given to striking a balance amongst protecting public health, free flow of information and freedom of choice of consumers. Mrs CHOW disagreed with the establishment of a pre-market approval mechanism and the enactment of a new piece of legislation to regulate health claims, as this would invariably inhibit investment and dampen the development of the health food industry, not to mention undermining freedom of choice of consumers. Mrs CHOW then asked whether claims made by health food product on prevention of breast lumps would be prohibited under the proposed revised framework of regulation. DDH responded that the claims relating to the prevention, elimination or treatment of breast lumps would be prohibited as they carried high risk.

44. Dr LO Wing-lok said that different places had different ways of regulating health food. He referred the meeting and the public to the three research reports prepared by the Research and Library Division of LegCo Secretariat on the regulation of health food in Taiwan, Australia and the United States of America, which were available on the LegCo Web Site. Dr LO further said that formulating a comprehensive regulation of health claims should best be carried out after the completion of registration of PCM in several years' time. By then, the extent of orally consumed products which needed to be regulated would be made clear, as all orally consumed products containing pharmaceutical or medicinal ingredients would then be registered either under the Pharmacy and Poisons Ordinance or the Chinese Medicine Ordinance. In the meantime, the medical

professional bodies supported the Administration's plan to regulate claims made by health food products.

45. Dr LO however pointed out that there were numerous deficiencies in the Administration's revised proposal on regulation of health claims, which needed to be addressed. For instance, claims such as "eliminates toxins" or "cleanses toxin elements in the body" would mislead people to believe that a health food product making such claims could treat food poisoning or heavy metal poisoning and could remove toxins from the body due to renal failure, etc. Allowing a food product to make claims such as "improves immunity" and "strengthens the immune system" was also unacceptable, as immunity, apart from innate or natural immunity that occurred as part of an individual's natural biologic makeup, could only be acquired by the development of antibodies after an attack of an infectious disease or by a pregnant mother passing antibodies through the placenta to a fetus or by vaccination. Another example was the ambiguous meaning of the claim "Suitable for people concerned about blood sugar", as did it mean that it was safe for people suffering from diabetes to consume the food product making such a claim or did it mean it would be beneficial for this group of people.

46. DDH responded that the claims "Suitable for people concerned about blood sugar/blood pressure/blood lipids or cholesterol" could be allowed, so long as the products making such claims were not registered under the Pharmacy and Poisons Ordinance or the Chinese Medicine Ordinance and that they must explicitly say so in the form of a disclaimer both on the packaging and in the advertisement. As to allowing a product not registered under the Pharmacy and Poisons Ordinance or the Chinese Medicine Ordinance to make a general claim about immunity and detoxification, DDH said that the Administration considered this acceptable so long as such claims were made in a very general sense without reference to improvements to any specific body functions and that both the product label and advertisement would clearly include a disclaimer that "This is not a registered pharmaceutical product or a registered proprietary Chinese medicine". Hence, consumers should be able to judge that products making the aforesaid claims did not have curative or preventive effects on the diseases concerned. More importantly, claims on regulation of blood sugar/blood pressure/blood lipids or cholesterol/body immune system against diseases (including cancers, chronic diseases and infection) or alteration of the effects of treatment (including chemotherapy and radiotherapy) and promotion of detoxification, including eliminating heavy metals, removing carcinogenic substances in the body and removing drug remnants, would be prohibited.

47. Dr LO remained of the view that allowing a product not registered under the Pharmacy and Poisons Ordinance or the Chinese Medicine Ordinance to make a general claim on detoxification was unacceptable, unless it was clearly included

in the disclaimer that the product could not remove specified toxins. DDH reiterated his points made in paragraph 46 above, and further said that according to experts in CM, detoxification was also a general concept without reference to improvements to any specific body functions.

48. Ms LI Fung-ying said that the revised proposal on the regulation of health claims still had too many grey areas, which needed to be addressed before implementation. For instance, it was unclear whether "lingzhi" should be regulated as medicine or health food. Another example was that it was hard for the general public to comprehend as to why the claim "Suitable for people concerned about blood sugar" should be allowed, whilst the claim on prevention and cure of blood sugar should be prohibited.

49. Mrs Sophie LEUNG said that regulation of health claims should not be considered merely from a western medicine standpoint, and should incorporate that of CM.

50. Mr Andrew CHENG said that apart from regulating health claims through legislative means, education also played an important role to enable consumers make informed choices. In the light of this, Mr CHENG urged the Department of Health (DH) to launch programmes to educate the public on the concept of health and proper use of health products. In response, DDH said that public education on this front would be further stepped up.

51. In summing up, the Chairman urged the Administration to withhold introducing a bill into LegCo early next year to amend the UAMO, in view of the concerns/views raised by members about the proposal on the regulation of health claims.

VI. Commitment for the fight against SARS
(LC Paper No. CB(2)524/03-04(08))

52. DSHWF briefed members on the funding position of the $700 million commitment created for the fight against the Severe Acute Respiratory Syndrome (SARS), details of which were set out in the above Administration's paper.

53. Mr Andrew CHENG noted that pending finalisation of the detailed funding applications, a sum of $200.8 million under the commitment was reserved to meet the additional expenditure incurred for the treatment of patients, strengthening of infection control including the facility improvement works conducted on an emergency basis during the SARS outbreak at public hospitals and to cover the expenditure incurred on the provision of temporary quarters to frontline medical

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staff during the SARS crisis. In the light of this, Mr CHENG asked whether a detailed breakdown of the reserved sum of $200.8 million could be made available to members by the next meeting. DSHWF agreed.

Admin

54. Dr LO Wing-lok noted that a portion of the $383.2 million was allocated to HA to meet its additional expenditure incurred up to June 2003 for recruiting 1 081 additional healthcare and other staff. In the light of this, Dr LO requested for a breakdown of these staff in terms of types and numbers, such as how many of them were doctors and nurses, and their length of employment. Director HA undertook to provide the requested information after the meeting.

HA

VII. 56MM - Enhancement of infection control facilities in the public hospital system (Batch A) - increase in approved project estimate
(LC Paper No. CB(2)583/03-04(01))

55. Principal Assistant Secretary for Health, Welfare and Food said that the words "隔離病房" in the Chinese version of the last line of paragraph 3 of the above Administration's paper should be replaced by "病床床頭裝備". Director of Architectural Services (D ArchS) followed to brief members on the proposal to increase the approved project estimate of the project 56MM "Enhancement of infection control facilities in the public hospital system (Batch A)". Subject to members' view, the Administration intended to seek endorsement from the Public Works Subcommittee (PWSC) of an increase of $68.1 million in the approved project estimate for 56MM from $287.2 million to $355.3 million in money-of-the-day (MOD) prices on 17 December 2003.

56. D ArchS and Director HA supplemented that the main reasons for an increase of $68.1 million in the approved project estimate for 56MM were as follows -

(a) As the project was planned and had to complete within an extremely tight timeframe, the usual approach of developing detailed user requirements and working out detailed cost estimates before seeking funding approval for the Finance Committee was not followed. However, in the course of developing detailed user requirements and detailed cost estimates later on, it was found that the scope of works for each hospital had to be adjusted according to the actual size configurations and site constraints. In some cases, the works had to be carried out in a larger area than originally estimated. Attempt was therefore made to make use of hospital space to provide more bed head services so that the isolation rooms, when used as general

wards in normal times, could accommodate a larger number of patients. The estimated additional funding required to provide the additional bed head and other associated facilities was $5.2 million in MOD prices;

(b) In the course of the works, unforeseeable problems that required additional expenditure to resolve arose. In particular, the building conditions of some of the wards were neither satisfactory nor fit for conversion into isolation rooms. These problems included concrete spalling, water penetration and pipeworks which were at the end of their serviceable life. Most of these problems were not discernable whilst the wards were in active use; some could only be identified when works had actually started. The estimated additional funding required for the unforeseeable repair, rectification and major alteration works was $48.1 million in MOD prices; and

(c) In order to carry out the works under 56MM, it was necessary to arrange decanting of the existing hospital wards. As most of the hospital services provided by these wards were essential, diversion works for building services such as plumbing and drainage as well as medical gas and hot water supply systems to ensure that the existing hospital services could continue elsewhere in the hospital must be carried out. The estimated additional funding required for the decanting and services diversion works was $14.8 million in MOD prices.

57. DSHWF pointed out that due to constraints posed by the actual site configurations, the number of beds that the non-intensive care unit (ICU) isolation rooms could accommodate would be 784, as opposed to 871 originally planned, upon completion of works if the isolation rooms were to accommodate one, two or four beds during an infectious disease outbreak. Nevertheless, in order to maintain existing hospital services and to meet the operational needs of the hospitals during normal times, there was a need to fit out and make provisions for the use of additional beds in the isolations rooms to accommodate up to eight patients when the isolation rooms were used as general wards during normal times. This meant that upon the completion of works under 56MM, the total number of beds that the non-ICU isolation rooms could accommodate at normal times would be 868, i.e. these rooms could accommodate 84 more patients when not being used as isolation rooms. DSHWF further pointed out in that the course of works, it was found that there was room to provide more isolation beds in the ICUs of five hospitals. Taking into account that ICU isolation beds could be used as non-ICU isolation beds but not vice versa, opportunity had therefore been taken to make use of the space available to provide more ICU isolation beds than the originally

planned 19 ICU isolation beds. This meant that upon completion of the works under 56MM, there would be 40 additional ICU isolation beds in the hospitals concerned. In sum, the total number of isolation beds that could be provided in the isolation rooms and ICUs during an infectious disease outbreak was 843, which was 47 beds less than the originally planned number of 890. However, taking into account the 84 additional beds that could be provided when the isolation rooms were used as general wards at normal times, the total number of beds provided by 56MM would be 927.

58. Dr LO Wing-lok asked why the proposal only covered six major acute hospitals, having regard to the fact that a total of nine major acute hospitals had been identified for undergoing enhancement of infection control facilities.

59. Director HA explained that enhancement of infection control facilities works at the remaining three major acute hospitals, namely, the Alice Ho Miu Ling Nethersole Hospital, KWH and the United Christian Hospital, was under project 57MM, the works of which were contracted out by HA to private firms. To date, no additional funding was required under 57MM.

60. Ms LI Fung-ying and Mr Andrew CHENG expressed concern about the significant additional funding required for project 56MM. Mr CHENG further said that the Administration should provide explanation in its funding proposal to PWSC as to why 56MM required additional funding whereas that was not the case for 57MM.

61. Due to time constraint, the Chairman said that members could follow up with the Administration on project 56MM at the meeting of PWSC 17 December 2003. Members agreed.

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

Council Business Division 2
Legislative Council Secretariat
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