立法會
Legislative Council

LC Paper No. CB(2)2367/03-04
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 19 April 2004 at 8:30 am
in the Chamber 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 Cyd HO Sau-lan Hon CHAN Yuen-han, JP Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP Hon Jasper TSANG Yok-sing, GBS, JP Dr Hon YEUNG Sum Hon Andrew CHENG Kar-foo Dr Hon LAW Chi-kwong, JP Dr Hon TANG Siu-tong, JP Hon LI Fung-ying, JP
Member absent	:	Hon CHAN Kwok-keung, JP
Public Officers attending	:	All items Mr Thomas YIU, JP Deputy Secretary for Health, Welfare and Food (Health)

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Mr Nicholas CHAN
Assistant Secretary for Health, Welfare and Food (Health) 6

Item IV

Dr T H LEUNG
Deputy Director of Health

Mr Jeff LEUNG
Principal Assistant Secretary for Health, Welfare and Food (Health) 1

Dr Shirley LEUNG
Principal Medical & Health Officer (Family Health Service), Department of Health

Item V

Dr W M KO, JP
Director (Professional Services & Human Resources)
Hospital Authority

Mrs Ingrid YEUNG
Principal Assistant Secretary for Health, Welfare and Food (Health) 2

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)1955/03-04)

The minutes of the meeting held on 8 March 2004 were confirmed.

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II. Information paper issued since the last meeting
(LC Paper No. CB(2)1840/03-04(01))

2. The Chairman sought members' view on the above letter from a quadriplegic patient requesting Members to debate on the issue of legalising euthanasia in Hong Kong.

3. Dr LO Wing-lok advised that the issue of legalising euthanasia in Hong Kong had been debated by the Legislative Council (LegCo) during the motion debate on "Treatment of Terminal Patients" at the Council Meeting on 2 May 2001, of which he was the mover. As the motion was negatived, Dr LO was of the view that there was no need to embark on another debate on the issue of legalising euthanasia in Hong Kong. Detailed account of the debate was available on the LegCo Website.

4. As the contact address of the quadriplegic patient was not known, the Chairman called upon the media to convey members' encouragement and support to the individual concerned.

5. Director, Hospital Authority (Director, HA) advised that much had been done in recent years to provide better support and improve care to terminally ill patients and patients in serious condition. For instance, apart from continuously improving hospice and chaplaincy care, comprehensive guidelines on the treatment of these patients, including providing guidelines to help health care personnel make decisions about life-sustaining treatment based on professional requirements and ethical standard had been developed.

III. Date of next meeting and items for discussion
(LC Paper Nos. CB(2)1956/03-04(01) and (02))

6. As the next regular meeting coincided with the overseas duty visit of the Panel on Manpower and the annual HA Convention of which some members would be attending, the Chairman suggested and members agreed to reschedule the next regular meeting from 10 to 17 May 2004 at 8:30 am.

7. Members further agreed to discuss the following items at the next regular meeting in May 2004 -

(a) Way forward on the regulation of health care personnel not currently subject to statutory registration; and

(b) Rehabilitation services for discharged mental patients.

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8. Referring to Clause 4.1.2 (ii) of the Conditions of Tender for the procurement of pharmaceutical products by the Government and HA set out in the Appendix to the list of follow-up actions (LC Paper No. CB(2)1956/03-04(02)), Dr TANG Siu-tong enquired about the reason(s) for requiring drug manufacturers outside Hong Kong to produce marketing authorisation of the drugs from a member country of the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use, or from the national control authority of the People's Republic of China, Australia or Canada, apart from producing a Certificate of Drug/Product Registration of the drugs issued by the Pharmacy and Poisons Board of Hong Kong. Deputy Secretary for Health, Welfare and Food (DSHWF) undertook to provide a written response to Dr TANG's question after the meeting.

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IV. Rationalization of maternal and child health services
(LC Paper No. CB(2)1956/03-04(03))

9. Deputy Director of Health (DDH) took members through the above Administration's paper which set out the continuous efforts of the Department of Health (DH) to improve its Maternal and Child Health (MCH) services to meet community needs and DH's plans to rationalise provision of the services. DDH further said that the Robert Black MCH Centre (MCHC) was incorrectly grouped under the Kowloon City district in the Appendix to the Administration's paper, and should be under the Wong Tai Sin district.

10. Ms LI Fung-ying said that she agreed in principle with the principles adopted for re-configuring the distribution of MCHCs set out in paragraph 13 of the Administration's paper. Ms LI however queried whether the planned closure of the Peng Chau, Tai O and North Lamma MCHCs would cause inconvenience to the residents, having regard to the fact that these centres were located in outlying islands. Mr Jasper TSANG expressed similar concern.

11. DDH responded that DH had consulted the clients of the Peng Chau, Tai O and North Lamma MCHCs who generally had no objection to the closure of these centres. As these centres only operated part-time due to low service demand and were dilapidated, most clients saw no problem in travelling a longer distance to other MCHCs better endowed with space, facilities, physical environment and accessibility by public transport. For instance, clients of Tai O MCHC did not express any resistance in attending the MCHCs in Mui Wo or Tung Chung with more comprehensive services. Many clients living on the Lautau Island in fact preferred to attend the MCHCs in the urban area as many of them would treat this as an outing to go shopping or meet friends after visiting the MCHCs. Moreover,

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clients could now make appointment to use the Child Health Services in MCHCs. As a result of the implementation of such appointment system since October 2003, attendances were now more evenly distributed amongst different sessions and the waiting time for service was markedly reduced. DDH further said that DH would soon start briefing district councils and their relevant sub-committees on its plan to rationalise provision of the MCH services.

12. Dr LO Wing-lok expressed support for the rationalisation plan of the MCHC services to achieve a more effective use of resources. Dr LO then asked the following questions -

(a) Whether any savings would be achieved from the rationalisation; if so, how such savings would be used; and

(b) What measures would be taken by MCHCs to ensure that all newly arrival infants and children were immunised against the nine common childhood infections.

13. DDH responded that the rationalisation of the MCH services would result in savings. Part of the resources released from the under-utilised centres, upon their merging with others, would be deployed to other centres to enhance their services. Meanwhile, DH was planning to review the Women Health Service in MCHCs. As regards Dr LO's second question, DDH said that a Service Handbook for New Arrivals, which included the immunisation service provided by MCHCs, published by the Home Affairs Department (HAD) were distributed to all new arrivals upon their entry into Hong Kong. The Handbook was also available at a number of Government departments (including Education and Manpower Bureau, Housing Department, Immigration Department and Social Welfare Department), non-governmental organisations involved in providing new arrival services and the HAD's Public Enquiry Services Centres across the territory. To ensure that all newly arrival infants and children aged below 6 had received the necessary types of immunisation, MCH staff would contact the parents concerned who failed to do so through the addresses provided by the Immigration Department. Opportunity would also be taken by DH staff to detect which children had failed to receive the necessary type of immunisation when carrying out immunisation in schools.

14. Responding to Dr LO's further enquiry as to whether consideration would be given to deploying junior doctors working in the MCHCs to receive specialist training at HA hospitals, DDH said that there was a structured training programme for such and work in this regard would be strengthened.

15. In view of the significant drop in attendances at MCHCs brought about by a

33% decline in birth rate from 1992 to 2002, the Chairman enquired how this had affected staff deployment in these centres.

16. DDH responded that due to natural wastage, the implementation of the Voluntary Early Retirement Scheme and re-deployment of surplus staff to other areas of work within DH, no MCHC staff had been made redundant because of the drop in attendances at MCHCs.

17. The Chairman further asked whether there was any plan to re-deploy MCHC staff made surplus as a result of the rationalisation of the MCH services to work at the new Centre for Health Protection (CHP). DDH responded that surplus nurses at MCHCs with appropriate training might be deployed to work at the CHP.

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

(a) Whether MCH services in the Yuen Long district would be strengthened to meet the demand of the growing population in Tin Shui Wai North;

(b) Whether sites vacated by the eventual closures of the 16 part-time MCHCs and four full-time MCHCs would be handed over to the Government Property Agency (GPA); and

(c) How had the resources saved from the drop in demand for MCH services been utilised.

19. DDH responded that the rationalisation of MCH services in the Yuen Long district would not reduce MCH services to people living in Tin Shui Wai North. There would still be two full-time MCHCs with enhanced services, of which their scale of operation would be two to three times that of the old MCHCs. DH was confident that with the upgrading of MCH services in the Yuen Long district, the MCHCs thereat could cope with the service demand from Tin Shui Wai North. As regards Dr TANG's second question, DDH said that DH would return the sites vacated by the 20 MCHCs to GPA if it could not identify ways to put these sites to good use. DDH assured members that DH would not drag on this process. As to Dr TANG's last question, DDH said that part of the resources saved from the drop in demand for MCH services had been deployed to launch new services and improve existing services provided by DH.

20. Dr LAW Chi-kwong suggested renaming MCHC as, say, "Woman and Child Health Centre", to avoid single women from feeling embarrassed to use the Women Health Service thereat. Mrs Sophie LEUNG also said that the Women's

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Commission considered the name "Community Health Centre" could better reflect the range of services provided by MCHCs. The Chairman shared Dr LAW and Mrs LEUNG's views. Dr LO Wing-lok however said that he did not see the need for changing the name of MCHC, which was deeply imprinted in the minds of the public at large. Moreover, additional expenditure would be incurred to change the signage, letterheads, etc. DDH agreed that the name of MCHC might need to be changed to better reflect its services, and consideration was being given in this regard.

21. Dr LAW Chi-kwong hoped that the Administration would expeditiously roll out the provision of Women Health Service, presently provided in 10 MCHCs, to the remaining MCHCs to better protect the health of women. As only 10 MCHCs at present provided Women Health Service, Dr LAW further hoped that more publicity could be carried out to apprise women of the locations of these 10 centres.

22. DDH responded that it was DH's intention to have Women Health Service in all MCHCs, and an implementational plan would be developed in light of the pace of demand for such service. DDH further said that DH would step up efforts to publicise the names and locations of the MCHCs with Women Health Service.

23. Mrs Sophie LEUNG hoped that consideration could be given to expanding the scope of service provided by MCHCs to better community needs, such as organising talks on mental health in selected districts. Mrs LEUNG further said that MCHCs were a suitable platform in enhancing collaboration between the public and private sectors on the delivery of health care service. In response, DDH said that he would carefully consider Mrs LEUNG's suggestions.

24. In summing up, the Chairman said that members were supportive of the rationalisation plan of MCHCs. In so doing, the Chairman urged DH to ensure that service quality would not be compromised.

V. Financial situation of the Hospital Authority
(LC Paper No. CB(2)1956/03-04(04))

25. DSHWF briefed members on the financial situation of HA in 2004-05 and the measures HA would implement to address its budget deficit problem, details of which were set out in the above Administration's paper. DSHWF also advised members of an error in paragraph 2 of the Chinese version of the paper that the figures under 2003-04 should be under 2004-05 and vice versa.

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26. Dr YEUNG Sum said that the public health care system could no longer be sustained in the long run if it was to be heavily subsidised, in view of the growing ageing population, increasing public expectation for better services, and need for enhancing primary and preventive care and infection control. In the light of this and given Hong Kong's low taxation system, Dr YEUNG urged the Administration to expeditiously come up with options of long term health care financing for public discussion. Dr YEUNG further sought confirmation as to whether there was any truth in a recent newspaper reporting that HA was planning to try out a scheme of inviting civil servants to make voluntary contribution to a medical insurance scheme. Dr YEUNG was of the view that one way to attract people to join such a scheme was to provide them with tax concession.

27. DSHWF responded that the Administration planned to consult members on the options of long term health care financing, including the Health Protection Account (HPA) scheme proposed in the Consultation Document on Health Care Reform, in June 2004. HPA was essentially a personal savings account to cover the future medical needs of the individual and the spouse when the individual reached the age of 65 or earlier in case of disability. It should be noted that savings from HPA were not expected to be adequate in all cases to cover the medical expenses of the individual and the spouse, as they were intended to be used as a supplementary source of funds for the individual and the spouse to pay for their medical expenses after retirement.

28. As regards the voluntary medical insurance scheme, DSHWF said that HA was presently conducting a viability study of such a scheme. If implemented, the potential contribution of voluntary insurance would be one of the sources of supplementary funding of the health care system and that it could provide greater choice. DSHWF pointed out that the voluntary insurance scheme was not targeted at civil servants. The viability study on the voluntary insurance scheme was still at a very preliminary stage, and the question of which sectors of the population that the scheme should target at had not yet been examined.

29. Director, HA supplemented that the viability of a voluntary medical insurance scheme as one of the options of long term health care financing was predicated on two elements. Namely, reasonable participation rate and that the participants were mainly users of public health care services. As civil servants could satisfy these two conditions, the consultants had therefore chosen this group as an example for their study on the viability of the voluntary medical insurance scheme. Director, HA further said that the long term sustainability of the public health care system could not be achieved without service rationalisation, fees restructuring, enhancement of public/private interface and the implementation of other financial/insurance arrangement. The first three areas had been and would continue to be pursued by HA. In so doing, it was inevitable that waiting time

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for certain elective/non urgent services would be longer and higher fees would be charged. However, no one would be denied of adequate medical care because of lack of means. It was hoped that the public could come to a consensus on the way forward on long term health care financing, without which any measures taken by the Government and HA to address HA's budget deficit could not fully address the problem.

30. Ms LI Fung-ying asked the following questions -

(a) How many HA staff had not reached the maximum salary point in their pay scale according to the contractual agreement in 2004-05, and what was the additional staff cost to be incurred;

(b) Why partial replacement of staff lost through natural wastage/Voluntary Early Retirement Scheme was one of the factors contributing to HA's deficit, given that new recruits should generally have been hired on a salary point lower than that of the staff who had left; and

(c) How would the fees chargeable to the medically stable infirmary HA patients to be placed under the care management of a non-governmental organisation (NGO) of the welfare sector, referred to in paragraph 4 of the Administration's paper, be determined.

31. Responding to Ms LI's first question, DSHWF said that the amount of salary increment of HA staff amounted to about $500 million per year. Breakdown of such staff cost could be provided to members after the meeting. As regards Ms LI's second question, DSHWF explained that the reasons why no significant savings could be achieved through natural wastage/Voluntary Early Retirement Scheme were twofold. Firstly, the current low staff turnover rate (outside the Voluntary Early Retirement Scheme) had made it difficult for HA to generate savings in staff cost to offset the increase due to salary increment. Secondly, HA had to set aside an one-off ex-gratia payment amounting to $54 million to staff who would leave in 2004-05 under the Voluntary Early Retirement Scheme. As to Ms LI's last question, DSHWF said that the fees chargeable to HA patients to be put under the care of an NGO would not be higher than those charged by HA. The exact fees to be charged would be determined by HA and the NGO concerned. Director, HA supplemented that apart from improving the continuity of care, the approach of developing a community-focused, patient-centred health care service had enabled HA to provide more cost-effective delivery of health services and reduce demand on the more expensive inpatient services. This was in line with international development in patient care and was financially more sustainable.

32. Ms LI further enquired about the number of NGOs which HA had engaged to provide care for HA patients in non-hospital settings. Director, HA responded that the development of a community-focused and patient-centred health care service was about the development of a new mode of service delivery involving the participation of the community. The Visiting Medical Officer Scheme for residential care homes for the elderly to improve the quality of care and to reduce hospital admission for elders was a case in point. A similar approach was also adopted for psychiatric service. In line with the international trend, there would be a shift in focus from institutional rehabilitation, which was not necessarily the best treatment and was more expensive, to community-based rehabilitation for patients with mental illness.

33. Dr LO Wing-lok asked the following questions -

(a) Whether there was a mechanism for the Administration to monitor the fees and charges charged by HA, having regard to the fact that HA was allowed to retain its income from fees and charges apart from other non-medical sources;

(b) Why HA was allowed to retain the interest generated from its income;

(c) What would be the increase in the amount of expenditure in employees insurance and legal fee in 2004-05, as a result of the Severe Acute Respiratory Syndrome outbreak in 2003;

(d) What was the reason for HA to continue with the "Better Health for a Better Hong Kong" territory wide campaign targeting at prevention of common infectious diseases, after the establishment of the CHP;

(e) Whether the downloading of patients, albeit in stable condition, from the specialist outpatient (SOP) clinics to general outpatient (GOP) clinics would undermine primary care;

(f) Where would the financial resources for HA to contract out its GOP services to private providers come from, having regard to the fact that about 80% of HA funding was spent on staff cost; and

(g) Whether the new procurement policy for medical equipment, mentioned in paragraph 10 of the Administration's paper, would result in HA making less purchases of advanced technology medical equipment.

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34. Responses given by DSHWF and Director, HA to the questions raised by Dr LO in paragraph 33 above were summarised as follows -

(a) There was no cause for concern that HA would increase and/or introduce new fees and charges to boost its income, as Government's funding to HA was based on the amount HA needed to provide its services less estimated income generated from fees and charges and other non-medical sources, including interest;

(b) HA would need to seek the endorsement of the Health, Welfare and Food Bureau before introducing any new fees and charges for its services, with the exception of private services based on the prevailing rates charged by private providers;

(c) Main reason for fees restructuring was not to generate income but to avoid misuse so that heavily subsidised services could be used on patients most in need;

(d) Every effort would be made to ensure that the work on the prevention of common infectious diseases between HA and DH/CHP would be well-coordinated to ensure effective use of resources;

(e) HA was anticipating proposals from the insurance sector on the employees insurance for its staff, and would report to members once a decision on the matter had been made;

(f) Downloading of stable chronic patients from SOP to GOP clinics was to promote better continuity of care and development of family medicine. It was envisaged that with such a move, primary care would be enhanced, which in turn would help to improve the overall health status of the population as well as contributing towards cost saving in the long run;

(g) HA had no plan to contract out its GOP services to the private sector this year, as more study needed to be made to assess the pros and cons of the arrangement. Although such a move could promote better public/private interface, patients' affordability was also an important determining factor; and

(h) As resources were finite, it was incumbent upon HA to exercise caution in making purchases of expensive advanced medical equipment. The principle was that HA would only do so if such

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equipment could bring about a significant improvement to treatment and was cost effective.

35. Due to time constraint, the Chairman suggested and members agreed to hold a special meeting to continue discussion on the financial situation of HA.

(*Post-meeting note* : Discussion on the financial situation of HA would continue at the next regular meeting scheduled for 17 May 2004.)

36. There being no other business, the meeting ended at 10:36 am.

Council Business Division 2
Legislative Council Secretariat
14 May 2004