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Legislative Council

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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 (the Panel) during the 2003-2004 Legislative Council (LegCo) session. It will be tabled at the Council meeting on 30 June 2004 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 13 members, with Hon Michael MAK Kwok-fung and Dr Hon LO Wing-lok elected as Chairman and Deputy Chairman of the Panel respectively. The membership list of the Panel is in **Appendix II**.

Major work

Reports of the SARS Expert Committee and the Hospital Authority Review Panel on the SARS Outbreak

5. Following the publication of the Report of the SARS Expert Committee in the morning of 2 October 2003, the Panel immediately met with representatives of the SARS Expert Committee in the afternoon of that day. As the Report only focused on lessons to be learnt and formed the judgment that it "has not found any individual deemed to be culpable of negligence, lack of

diligence or maladministration" in the handling of the Severe Acute Respiratory Syndrome (SARS) epidemic, the Panel recommended to the House Committee on 10 October 2003 that a select committee be appointed by the Legislative Council (LegCo) to inquire into the handling of the SARS outbreak by the Government and the Hospital Authority (HA). The House Committee supported the Panel's recommendation and decided to form a subcommittee to formulate the terms of reference and other related matters. The select committee was subsequently appointed by LegCo on 29 October 2003.

6. The Panel also met with representatives of the HA Review Panel on the SARS Outbreak (the Review Panel) on 23 October 2003 to discuss the Report of the Review Panel. Issues raised with the Review Panel included collaboration with the Department of Health (DH), command and control structure of HA during the SARS outbreak, capacity of HA and its preparedness to deal with a major crisis and impact of SARS on HA's funding.

7. On 9 October 2003, the Panel decided to form a subcommittee to monitor the implementation of the recommendations of the SARS Expert Committee by the Government and HA. The scope of the subcommittee was later expanded to cover the monitoring of the implementation of the recommendations of the HA Review Panel at the first meeting of the subcommittee on 17 October 2003. Issues discussed by the subcommittee included contingency mechanism of the Government and HA to deal with possible resurgence of SARS, manpower requirement for combating SARS, engaging the community in times of outbreak, communications and review of the existing legislation for the control of infectious diseases. Members were generally satisfied with the progress made by the Administration and HA in implementing these recommendations. They, however, urged the Administration to expedite a comprehensive revamp of the Quarantine and Prevention of Disease Ordinance (Cap. 141), having regard to the operational experience in combating the recent SARS epidemic and the changing patterns of international trade and people movement.

Support measures for SARS patients and their families in the context of the outbreak from March to June 2003

8. The Panel held three meetings, including two joint meetings with the Panel on Welfare Services, in October and early November 2003 to discuss the Administration's proposal to establish a $130 million Trust Funds for SARS to provide, on compassionate grounds, financial assistance to families of deceased SARS patients and those recovered SARS patients who contracted SARS during the outbreak in Hong Kong from March to June 2003. At the request of members of the two Panels, the Administration agreed to increase the earmarked sum for recovered SARS patients from $50 million to $70 million,

thereby increasing the global amount to $150 million. The Administration also agreed to expand the scope of the proposed Trust Fund to also cover "suspected "SARS patients treated with steroids who subsequently turned out not to have SARS. The proposed Trust Fund was formally established on 8 November 2003, following the approval of the creation of a new commitment of $150 million by the Finance Committee (FC) on 7 November 2003.

Checklist of measures to combat SARS

9. In November 2003, the Administration introduced the Panel to a checklist of measures to combat SARS which contained, inter alia, the development of a three-level response system to ensure an efficient and responsive internal management system to combat the disease. The main features of the system are -

(a) Alert Level Response will be activated when there is a laboratory-confirmed SARS case outside Hong Kong; or a SARS Alert, as defined by World Health Organization (WHO), in Hong Kong;

(b) Level 1 Response will be activated where there is one or more laboratory-confirmed SARS cases in Hong Kong occurring in a sporadic manner; and

(c) Level 2 Response will be activated when there are signs of local transmission of the disease.

When the Alert Level Response is triggered, the Health, Welfare and Food Bureau (HWFB), DH and HA are the three main parties assessing the nature and level of risks, taking appropriate actions in anticipation of problems and monitoring developments. If Level 1 Response or Level 2 Response is activated, this will entail the establishment of a Steering Committee to steer Government actions.

10. Members were particularly concerned about the absence of an objective definition on signs of local transmission of SARS by which a "Level 2 Response" would be activated by the Government. The Administration agreed that it would be useful to have a definition of signs of local transmission of SARS. However, as there was no consensus amongst the health care community on the definition of local transmission of SARS, more time would be needed for the Administration to discuss with HA and other experts on coming up with such a definition. A member pointed out that according to WHO, local transmission of SARS occurred when one or more reported probable case of SARS most likely acquired their infection locally regardless of the setting in which this might have occurred.

11. Some members considered that the duties of the Steering Committee to steer Government actions during a Level 1 outbreak should include assessing whether Level 2 Response should be activated, and that the Secretary for Health, Welfare and Food (SHWF) and/or other person(s) should be appointed for making such a decision. They also raised queries why the Chief Executive of HA, who was a core member of the Steering Committee to steer Government actions during a Level 1 outbreak, was not a member of the Steering Committee to steer Government actions during a Level 2 outbreak. Neither was the Secretary for Economic Development and Labour a core member, despite the fact that one of the duties of the Steering Committee to steer Government actions during a Level 2 outbreak was to assess the socio-economic impact of the crisis on Hong Kong and to formulate measures to minimise the impact.

12. The Administration agreed that the duties of the Steering Committee to steer Government actions during a Level 1 outbreak should include assessing whether Level 2 Response or a lower level response should be activated, and SHWF should be the person responsible for making such decisions. As regards the composition of the Steering Committee to steer Government actions during a Level 2 outbreak, the Administration agreed to review in light of the suggestions raised by members.

13. A member considered that to ensure effective use of resources, money spent on remunerating private doctors under HA's Visiting Medical Officers (VMO) scheme to provide on-site medical care to residents of residential care homes for the elderly should be given to the end users, say, the home operators or the elderly residents. Another member, however, was of the view that it would not be a prudent use of public funds for HA to foot the bill for those home operators who were willing to pay for the services provided by VMOs. According to the feedback from the participants of the VMO project implemented during the SARS outbreak, over 40% of home operators indicated that they were willing to purchase service from VMOs if there was sufficient backup by HA's Community Geriatric Assessment Teams. The Administration agreed to take into account members' view in the future review of the VMO programme.

14. A member was of the view that the Administration should appoint a body to engage the community in combating SARS, so as to better utilise available resources in the community. The Administration, however, was of the view that a high level inter-departmental committee formed under the Government to coordinate resources from the community in times of outbreak might be a better option, as it was questionable whether a single government or quasi-governmental body could do the job effectively given the wide scope of resources in the community. By setting up an inter-departmental committee,

effective coordination of resources from the community could be better ensured by harnessing member departments' well-established connections with the trades concerned.

Collaboration on infectious disease surveillance amongst Guangdong Province, Hong Kong and Macao

15. The Administration reported to the Panel the progress made in the collaboration on infectious disease surveillance amongst Guangdong Province, Hong Kong and Macao in November 2003. Members were particularly concerned about the Administration's explanation that sudden upsurge of any infectious diseases of unknown nature or of public health significance generally referred to abnormal pattern of infection in the community. They were of the view that there should be clear and objective criteria in place so that each place would know when it was required to report promptly to the other two places.

16. The Administration advised that although there was no formal definition of sudden upsurge of any infectious diseases of unknown nature or of public health significance under the tripartite agreement on collaboration on infectious disease surveillance, the parties concerned had been working on the understanding that this referred to a general increase of infected cases above the normal level.

Notification mechanism on infectious diseases between Guangdong Province and Hong Kong

17. Members noted that the Government Virus Unit (GVU) of DH received a request from the Guangdong Province Center for Disease Control and Prevention (CDC) on 27 January 2004 for SARS coronavirus testing on the clinical specimens from a 40-year-old health care worker with pneumonia in Guangzhou. In the afternoon of 30 January 2004, GVU of DH reported the test results to the Guangdong Province CDC. On 31 January 2004, the Guangdong Province Health Department notified DH that the pneumonia patient was classified as a confirmed SARS case and that a press release would soon be issued. Members considered that the Guangdong health authorities should have notified DH as soon as the case was classified as a suspected SARS case and not after the case was confirmed as SARS. According to the agreement reached by the Guangdong-Hong Kong-Macao Expert Group on Prevention and Treatment of Infectious Diseases, one place should promptly report to the two other places of any sudden upsurge of infection of unknown nature or of public health significance.

18. In the light of public concern about the notification mechanism with Guangdong, the Administration advised that DH had written to the Ministry of

Health (MOH) in Beijing and the Guangdong Province Health Department to remind them of the need to keep DH informed of any suspected and confirmed SARS case. The Administration would continue to liaise with the Mainland health authorities for the betterment of the notification mechanism.

19. A member pointed out that the patient concerned was diagnosed by experts in Guangzhou on 24 January 2004 as a suspected SARS case and by experts in the Guangdong Province on 25 January 2004 as a confirmed SARS case. On 26 January 2004, MOH received a report of the patient concerned from the Guangdong Province Health Department. On 27 January 2004, China CDC requested GVU of DH for SARS coronavirus testing on the patient concerned. To speed up the notification process, the member suggested that the Guangdong Province Health Department should in future report to DH at the same time it reported to MOH. If that had been done, DH should have been advised of the suspected case two days earlier, i.e. 25 January instead of 27 January 2004. The Administration shared member's suggestion and might raise such with the Mainland health authorities.

<u>Preventive measures taken in Hong Kong against SARS</u>

20. The Administration briefed members on two occasions the preventive measures taken in Hong Kong against SARS, in light of the recurrence of SARS in some areas of Guangdong Province in late December 2003 and in Beijing and Anhui Province in April 2004. These measures included the following -

(a) health declarations and temperature screening checks for travellers at all border control points were maintained;

(b) extra port health staff had been deployed to distribute health information leaflets and health alert cards to travellers;

(c) relevant health messages were broadcast at all border control points;

(d) a surveillance system had been set up by DH and HA to monitor patients with pneumonia who had a history of travel to the affected areas during the 10 days before the onset of symptoms;

(e) DH had notified public and private hospitals, general practitioners, Chinese medicine practitioners, healthcare professionals including those working in laboratories to remain vigilant and to pass information about any patients with pneumonia symptoms and with history of travel to the affected

areas to DH to facilitate contact tracing and analysis;

(f) HA had implemented a monitoring system of staff on sick leave so that it would be alerted early to a cluster of staff falling sick with specific symptoms (e.g. fever and respiratory disease) to prevent the spread of infection in hospitals; and

(g) the Tourism Commission had reminded the travel trade of the need to remain vigilant and adhere to DH's guidelines.

Centre for Health Protection

21. The Administration consulted the Panel on 5 January 2004 on its proposal to establish a Centre for Health Protection (CHP) within DH with the following six functional Branches -

(a) Surveillance and Epidemiology Branch (SEB);

(b) Infection Control Branch (ICB);

(c) Emergency Response and Information Branch;

(d) Public Health Laboratory Services;

(e) Public Health Services; and

(f) The Programme Management and Professional Development Branch.

Apart from having the functional Branches, a programme-based approach would be used for developing a comprehensive health protection system. Health protection programmes would be set up to cover a list of priority health hazards. Such programmes served to bring experts from various agencies and disciplines together and adopt a multi-disciplinary approach to controlling health hazards.

22. Some members were concerned about the lack of a clear demarcation of duties and responsibilities between CHP and HA with regard to disease surveillance, epidemiology and infection control. For instance, it was unclear whether the ICB under the umbrella of CHP would replace HA's Hospital Infection Control Teams. The Administration explained that the work of ICB would not overlap with that of HA's Hospital Infection Control Teams as the responsibility of the latter was to implement the infection control protocol developed by ICB. As an integrated approach would be adopted by CHP to

control health hazards, infection control protocols for both public and private hospitals and other relevant entities, such as homes for the elderly, would not be developed solely by ICB. In the case of the development of infection control protocol for public hospitals, it would be developed in tandem with infection control experts from HA and other relevant organisations. There was no question of any confusion occurring in times of outbreaks of infectious diseases, as CHP would assume primacy in infection control work in times of outbreaks.

23. A member had reservation about establishing the proposed CHP as part of DH, having regard to the inability of DH to co-ordinate with HA and HWFB in the management of the SARS outbreak in Hong Kong. Another member also criticised that the setting up of the proposed CHP was more a restructuring of DH than setting up a new public health infrastructure to safeguard public health.

24. The Administration explained that despite the weaknesses in the present public health system to prevent and control communicable diseases, this did not necessarily mean that the proposed CHP should be established independent of the Government. In the Administration's view, a more pragmatic approach was to improve on the current system. The establishment of the proposed CHP would not merely be a restructuring of DH. The CHP would be a new public health infrastructure for consolidating existing diseases control strategies and address new challenges, such as emergency response to an outbreak. It would not only have professional knowledge and expertise in combating communicable and non-communicable diseases, but also the administrative skills and statutory power to co-ordinate various government departments and the community when taking appropriate measures to tackle health threats and respond to outbreaks.

25. The Administration also pointed out that most of the CHP-like organisations set up in countries such as Canada, Finland, Japan, New Zealand and Singapore were government agencies or government-owned entities. There was no cause for concern that because CHP was a government agency, its decisions would be influenced by political considerations. Most of the work for the prevention and control of communicable disease was carried out by frontline medical professionals. Occasions where the Director of Health would need to exercise his powers under the Quarantine and Prevention of Disease Ordinance (Cap. 141) would invariably involve major decisions such as imposing an Isolation Order on a whole residential block. The Administration could not see how such major decisions would not be made on grounds other than protecting the health of the public.

26. The CHP was formally set up on 1 June 2004 to take on the core functions of SEB and ICB in the first instance. The Administration envisaged that the CHP would become fully operational in 2005.

SARS-related capital work projects

27. The Panel was consulted on the proposal to increase the approved project estimate of project 57MM on the enhancement of infection control facilities in the public hospital system from $287.2 million to $355.3 million in money-of-the-day prices in December 2003. The proposal was endorsed by the Public Works Subcommittee (PWSC) on 17 December 2003 and approved by FC on 7 January 2004.

28. The Panel was also consulted on the construction of an infectious disease centre attached to Princess Margaret Hospital (PMH) in March 2004. Although supportive of the project, some members were concerned that this would pose public health threat to people living in the vicinity of PMH. The Administration assured members that there was no cause for concern, in view of the enhanced isolation facilities to be provided at the centre and the stringent infection control to be adopted by the new centre and PMH. Furthermore, with the coming into operation of the CHP in June 2004, infection control in all public hospitals and clinics would be further enhanced. The Administration also pointed out that the world trend was moving away from constructing a stand-alone infectious disease hospital that was distant from where the patients resided. In most instances where stand-alone infectious disease hospitals were used in overseas places, these hospitals were mainly for treatment of infectious disease patients in stable condition and/or recovered infectious disease patients. The proposal was endorsed by PWSC on 9 June 2004.

Regulation of health claims

29. The Administration consulted the Panel on the proposal to regulate health claims in December 2003. A number of members supported some forms of regulation on the claims on a risk-based approach, while other members requested that a comprehensive regulatory system to control “health food” products be set up in the longer term. To address members’ concerns, the Administration excluded three types of claims, namely, the regulation of the immune system, the promotion of detoxification and the promotion of slimming/fat reduction from its proposal, since these claims posed relatively lesser risk to public health and views on their regulation were divided.

30. The Undesirable Medical Advertisements (Amendment) Bill 2004 giving effect to the Administration's proposal to regulate health claims was introduced into LegCo on 11 February 2004. A Bills Committee was formed

by the House Committee on 13 February 2004 to scrutinise the Bill. The Bill is expected to lapse, as the House Committee decided on 11 June 2004 that no more Bills Committee would be activated.

Cervical cancer screening service

31. The Panel welcomed the launching of the cervical screening programme (CSP) by DH. Some members were, however, of the view that the proposed charge of $120 for cervical screening at DH's Maternal and Child Health Centres was on the high side and should be lowered. The Administration pointed out that as a woman would generally need to undergo cervical screening once every three years after two consecutive yearly negative smears, the cost for the service would only come up to $72 annually during a five years' period. Moreover, the existing medical fee waiver mechanism would also apply to needy users of DH's cervical screening service. Nevertheless, having regard to members' view, the Administration agreed to lower the proposed fee to $100. The CSP came into operation on 8 March 2004.

Regulation of medical devices

32. The Panel met with a total of 26 deputations in March 2004 to listen to their views on the Administration's plan to regulate medical devices. Members noted that the beauty trade in general supported the regulation of medical devices for safeguarding public health, but it was very worried that this would drive them out of business as the use of lasers and intense pulse light (IPL) equipment was fast becoming their main source of income. Representatives from the medical sector considered that the use and operation of high-powered lasers and IPL equipment should be confined to qualified doctors and dentists and other persons authorised by them.

33. The Administration clarified that it was not its intention to use the proposed regulation of medical devices to regulate a particular trade or to shift any services now provided through the use and operation of medical devices from one sector to another. As a first step, the Administration planned to implement an administrative control system in order to facilitate the transition to long-term statutory control. The administrative control would pave the way and lay the foundation for the legislative system. Manufacturers, importers and local representatives were invited to list their medical devices on a voluntary basis.

34. The Administration also assured members that it would see to it that the proposed regulation of medical devices would not undermine the business and the development of the beauty trade. The Administration's thinking was that beauty parlours should be allowed to continue to use high-powered medical

devices they presently possessed, provided that their personnel had received recognised training to use and operate such devices. The Administration would consider liaising with the Vocational Training Council in providing training programme for people working in the beauty trade, with a view to raising their standards in using medical devices.

Long-term heath care financing

35. The Administration reported to the Panel in June 2004 on the key findings of its initial research on the feasibility of establishing a Health Protection Account (HPA) scheme in Hong Kong. The HPA concept was a mandatory medical savings scheme in which individuals would put in a certain percentage of their monthly income into a personal account during working years, the savings accrued would be used to assist them in paying for medical services after retirement. For those patients who had managed to save very little or had already exhausted their savings because of frequent sickness, they would have the assistance of a safety net provided by the Government.

36. Members' views on the HPA scheme were mixed. Some of the views expressed were -

(a) the HPA scheme should not be made mandatory having regard to the fact that Hong Kong was still facing economic difficulties;

(b) the establishment of a mandatory social insurance scheme based on a risk-pooling concept should be re-visited; and

(c) the HPA scheme might not address the issue of sustaining the public health care system, given the modest percentage to be contributed by the working population and that such an arrangement would invariably tie participants of the scheme to use public health care system.

Members were, however, generally of the view that the Administration should explore other financing options and continue to work on areas such as containing public health care cost, promoting better public/private interface, transferring patients in stable condition and rehabilitation patients to receive ambulatory care in the community and revamping HA fees and charges to better target public subsidies to those in need, to address the issue of financial sustainability of Hong Kong's health care system.

37. The Administration clarified that no decision had yet been made on the way forward of the HPA scheme. It was hoped that, through this initial research, more discussion in the community about the health care financing

issue could be generated. Given the complexity of the subject and the far-reaching implications a new financing arrangement might have on the community and the economy, further studies would be needed to develop new financing options that would be sustainable in the long-term, and equitable and accessible to all members of the public. The Administration assured members that it would maintain the long-established principle that no one would be denied appropriate medical care due to lack of means. It would not introduce any new financing scheme unless it was supported by the general public and LegCo. In the meantime, the Administration and HA would continue to implement the short-term and medium-term measures to address the issue of financial sustainability of Hong Kong's health care system mentioned by members in paragraph 36 above.

Other issues discussed

38. Other issues discussed by the Panel included DH's adolescent health programme, progress on the regulation of Chinese medicine practitioners, regulation of proprietary Chinese medicines and provision of Chinese medicine service in the public sector, regulation of counterfeit pharmaceutical products, financial situation of HA, rationalisation of maternal and child health services, services and facilities for rehabilitation of discharged mentally-ill patients, way forward on the regulation of health care personnel not currently subject to statutory registration, and the current condition of Prince of Wales Hospital and the Government and HA's plans on the way forward.

Meetings held

39. From October 2003 to June 2004, the Panel held a total of 17 meetings, including two joint meetings with the Panel on Welfare Services.

Council Business Division 2
Legislative Council Secretariat
25 June 2004

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 for 2003 - 2004 session

Chairman	Hon Michael MAK Kwok-fung
Deputy Chairman	Dr Hon LO Wing-lok, JP
Members	Dr Hon David CHU Yu-lin, JP
	Hon Cyd HO Sau-lan
	Hon CHAN Kwok-keung, JP
	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
	(Total : 13 Members)
Clerk	Miss Mary SO
Legal Adviser	Miss Monna LAI
Date	31 October 2003