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LC Paper No. CB(2)995/08-09
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 9 February 2009 at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, JP (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon Andrew CHENG Kar-foo Hon Albert CHAN Wai-yip Hon Audrey EU Yuet-mee, SC, JP Hon Vincent FANG Kang, SBS, JP Hon Alan LEONG Kah-kit, SC Hon Cyd HO Sau-lan Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou
Member attending	:	Hon CHAN Kin-por, JP
Members absent	:	Hon Fred LI Wah-ming, JP Hon CHAN Hak-kan
Public Officers attending	:	Item III Dr York CHOW, SBS, JP Secretary for Food and Health Ms Sandra LEE, JP Permanent Secretary for Food and Health (Health)

Mr Ronald ARCULLI, GBS, JP
Chairman of the Working Group on Healthcare Financing of the Health and Medical Development Advisory Committee

Mr Thomas CHAN
Deputy Secretary for Food and Health (Health) 2

<u>Items III-V</u>

Professor Gabriel M LEUNG, JP
Under Secretary for Food and Health

<u>Item IV</u>

Miss Pamela LAM
Principal Assistant Secretary for Food and Health (Health) 1

Dr LEUNG Ting Hung, JP
Head, Surveillance & Epidemiology Branch
Centre for Health Protection

Dr Regina CHING, JP
Assistance Director of Health (Health Promotion)

<u>Item V</u>

Miss Gloria LO
Principal Assistant Secretary for Food and Health (Health) 2

Mr Shane SOLOMON
Chief Executive
Hospital Authority

Ms Nancy TSE
Director (Finance)
Hospital Authority

Dr K H LEE
Chief Manager (Financial Planning)
Hospital Authority

Clerk in attendance : Miss Mary SO
Chief Council Secretary (2) 5

Staff in attendance : Ms Maisie LAM
Senior Council Secretary (2) 7

Ms Sandy HAU
Legislative Assistant (2) 5

Action

I. Information paper(s) issued since the last meeting

There was no information paper issued since the last meeting.

II. Items for discussion at the next meeting
(LC Paper Nos. CB(2)774/08-09(01) & (02))

2. Members agreed to discuss the following items at the next meeting scheduled for 9 March 2009 -

(a) Inclusion of pneumococcal conjugate vaccine in the Childhood Immunisation Programme;

(b) Update on prevention and control measures on human avian influenza infection and pandemic preparedness; and

(c) Development of a territory-wide electronic healthcare record.

3. Ms Cyd HO proposed to discuss the issue of medical waiver mechanism of public hospitals and clinics at a future meeting, but before the publication of Stage two Public Consultation on Healthcare Reform.

III. Report on First Stage Public Consultation on Healthcare Reform

4. At the invitation of the Chairman, Secretary for Health and Food (SFH) and Mr Ronald ARCULLI highlighted the views received from the first-stage public consultation on healthcare reform from March to June 2008 as well as conclusions and way forward, details of which were set out in the Report on First Stage Public Consultation on Healthcare Reform released on 19 December 2008.

5. Mr Andrew CHENG asked about the measures which would be taken by the Administration to ensure that the low-income and underprivileged groups would not be deprived of adequate medical care through lack of means as a result of service reforms, such as the purchase of private services to promote public-private partnership (PPP) in healthcare, and implementation of healthcare financing.

Action

6. SFH responded as follows -

(a) services provided by the public sector including the Hospital Authority (HA) would not be reduced as a result of service reforms. The public sector would continue to serve as an essential safety net for the population, and additional resources would continue to be provided to HA to improve areas in need;

(b) strengthening public healthcare safety net was one of the four main areas of service reform. The Administration would press ahead with exploring ways to further strengthen the existing safety net with regard to reform on healthcare financing arrangements; and

(c) some members of the public expressed the view that HA should increase its basic fees and charges so that the additional income could be used to subsidise needy patients not on public assistance, and in that connection the idea of capping the medical expenses of chronic patients and patients who required lengthy and/or costly treatment would be further explored.

7. Ms Cyd HO suggested adopting a progressive rate to charge public patients based on their income, so that more resources could be deployed to assist needy patients not on public assistance. The determination of the progressive rate structure should be made with caution and in consultation with the public.

8. Ms Cyd HO asked whether the Administration would review its plan to implement mandatory medical savings or mandatory insurance as supplementary financing, in the light of the recent global financial turmoil.

9. SFH responded that the Administration was open minded on the supplementary financing arrangements to be adopted and had yet to come to a view on the matter. Work was underway to formulate more detailed proposals to further consult the public on the future development of Hong Kong healthcare system including the healthcare financing arrangement.

10. Ms Cyd HO hoped that more emphasis on the use of complementary medicine as preventive care to the elderly could be placed by the Administration in its healthcare reform. Ms HO further said that to better promote the well-being and quality of life of the elderly, the Food and Health Bureau and the Department of Health (DH) should join force with other government departments, such as the Housing Department, the Social Welfare Department (SWD) and the Leisure and Cultural Services Department, to come up with a programme to provide holistic and integrated services to the elderly, such as organising activities to meet the social and recreational needs of the more vulnerable and less well-off elders living in public housing estates.

Action

11. SFH responded that under the elderly health care voucher pilot scheme implemented in January 2009, senior citizens aged 70 or above were provided with five vouchers valued at $50 each annually to purchase private services provided by western medicine doctors, Chinese medicine practitioners, allied health professionals and dentists, etc. for preventive as well as curative care. One of the objectives of the three-year pilot scheme was to find out the types of healthcare services used by elders with the subsidy of vouchers, so that subsidies could be better targeted at areas most in need by elders.

12. SFH further said that DH had worked and would continue to work closely with SWD to provide holistic and integrated services to the elderly living in the community. SFH, however, pointed out that support from the community at large was also essential.

13. Mr Alan LEONG hoped that service reform would not result in people with lesser means having lesser choice of healthcare services, whereas people with more means would have more choice of healthcare services. Mr LEONG further asked about the timetable for taking forward the service reform.

14. SFH responded that service reform would not reduce the choice of patients with lesser means. For instance, the pilot scheme of subsidising public patients to undergo cataract surgeries in the private sector, the pilot scheme to purchase primary care services from the private sector in Tin Shui Wai for specified chronically-ill patients and the pilot elderly healthcare voucher scheme would in fact provide patients with more healthcare choices regardless of their means. With more PPP in healthcare, the capacity of the private sector would increase, which in turn would create more choices for patients and make prices charged by the private sector more transparent and competitive. As regards the timetable for taking forward the service reform, SFH hoped to launch a new initiative by 2009-2010 to further develop family medicine and improve primary care.

15. In response to Mr LEONG's further enquiry on when stage-two public consultation on healthcare reform would be launched, SFH said that the Administration would do so at an appropriate juncture upon the completion of the formulation of more detailed proposals on the future development of Hong Kong healthcare system, including the healthcare financing arrangement.

16. Dr LEUNG Ka-lau said that being a publicly-funded body, it was incumbent upon HA to let the public how and where its money was spent. Dr LEUNG suggested that HA should follow the practice of private hospitals to itemise costs in the patient bill.

17. SFH responded that as the bulk of HA cost was staff cost, i.e. about 85%, it would not be too meaningful to itemise costs in the patient bill, not to mention the high administrative cost involved. Nevertheless, in order to improve the fairness and transparency of resource allocation within HA, plan was in hand to

Action

implement a new "Pay for Performance" internal resource funding system through the adoption of a casemix approach.

18. Dr LEUNG Ka-lau queried whether the adoption of the family medicine model in HA general out-patient clinics could help to alleviate the heavy workload of HA specialist out-patient clinics.

19. SFH responded that overseas experience revealed that if family doctors could perform their gatekeeper role effectively, patients' demand for specialist care could be reduced. To achieve such would, however, require the collaboration of the medical sector and awareness of the public of the role played by family doctors.

20. Dr PAN Pey-chyou said that in view of the divergent views on the healthcare reform proposals, qualitative analysis of these views should be made.

21. Deputy Secretary for Food and Health (Health) 2 advised that to facilitate collation and assessment of views on the healthcare reform proposals, independent consultants were commissioned to conduct questionnaire surveys and focus groups discussions on both service reform and financing reform and targeting both the general public and specific groups. A brief description of the questionnaire surveys and focus groups conducted was at Appendix V to the Report on First Stage Public Consultation on Healthcare Reform. The detailed reports and results of the surveys and focus groups were available on the Healthcare Reform website. Reference had also been made to a number of questionnaire surveys conducted by third-parties when analysing public responses to the healthcare reform.

22. Mr Albert CHAN expressed opposition to the implementation of mandatory medical savings accounts or mandatory private insurance as a supplementary healthcare financing, having regard to the high fund management fee that might eat up savings balance and investment return as in the case of the Mandatory Provident Fund and the volatility of the financial markets. Mr CHAN was of the view that public healthcare should either be funded by taxation or user fees based on the income of users. Mr CHAN further said that before asking the public to contribute towards supplementary healthcare financing, details on how such financing could improve existing healthcare services should be provided.

23. SFH reiterated that the Administration was open minded on the supplementary financing arrangements to be adopted and had yet to come to a view on the matter. SFH pointed out that regardless of what form the supplementary financing would take, the Government had the responsibility to ensure its sustainability. On the suggestion of charging user fees for public healthcare services based on users' income, SFH said that this would likely entail prohibitively high administrative cost and would thus be very difficult, if not infeasible, to implement. Moreover, even better-off patients would have

Action

difficulty to pay the medical bill if they had heavy and/or long-term need of healthcare. As to providing details on how supplementary financing could improve existing healthcare services, SFH said that such details would be included in the Stage two Public Consultation on Healthcare Reform.

24. Ms Audrey EU asked about the timetable for completing PPP in healthcare. Ms EU further asked about the measures to address some public concern over senior executive remuneration in HA.

25. Responding to Ms EU's first question, SFH said that the Administration had not fixed a timetable for completing PPP in healthcare. As a start, focus was placed on improving the cost/price transparency and service quality of the private sector so as to attract more patients to use private sector service. The implementation of a territory wide electronic healthcare record, which was being developed, would help to quicken the pace of PPP in healthcare.

26. As regards Ms EU's second question, SFH said that being the largest public organisation in Hong Kong providing the bulk of secondary and tertiary healthcare, it was necessary for HA Board to remunerate senior management staff at an appropriate level to attract and retain them. SFH further said that HA would continue to control senior staff cost at a reasonable level and to ensure that it was value-for-money. For instance, some Hospital Chief Executives (HCEs) were overseeing more than one public hospital.

27. Mr Albert HO asked how the Administration would reconcile the divergent views on the six supplementary financing proposals put forth in the Consultation Document.

28. SFH responded that although there was not yet a consensus on the healthcare financing proposals, findings of the first stage public consultation clearly revealed some general values held by the public, for instance they wished to have more choices in healthcare to cater to their respective needs. The Administration would incorporate such values in the formulation of healthcare financing arrangement for stage-two public consultation.

29. Mr CHAN Kin-por said that healthcare reform must be fair to the middle-class who paid most of the tax to fund the public healthcare system. To deprive the middle-class of the medical safety net just because they had assets was unacceptable.

30. SFH responded that HA was the safety net for the people of Hong Kong, regardless of their means. SFH further said that one of the main objectives of supplementary healthcare financing was to provide the middle-income group with more value-for-money healthcare services, more quality choices and more comprehensive healthcare protection.

Action

31. In closing, the Chairman urged the Administration to provide a timetable for discussing medical fee waiver mechanism, remuneration of senior executives of HA and promotion of public/private interface.

IV. Progress report on promoting healthy eating among school children
(LC Paper Nos. CB(2)774/08-09(03) & (04))

32. Ms Cyd HO said that to facilitate more meaningful discussion, the Administration should provide information on the effectiveness of the "EatSmart@school.hk" Campaign (the Campaign) in reducing obesity among participating school children.

33. Under Secretary for Food and Health (USFH) responded that as the Campaign was only launched in the 2007-2008 academic year, it was not possible to measure the outcome of the Campaign on combating obesity among school children participating in the Campaign. Recent study on the effectiveness of the Campaign was hence focused on how the Campaign had changed the school environment, awareness, knowledge and attitude towards healthy eating as well as eating behaviour among students and parents as a result of the Campaign, details of which were set out in paragraphs 15 to 19 of the Administration's paper (LC Paper No. CB(2) 774/08-09(03)). USFH further said that although hard outcome measure of the Campaign could not be made available in the short term, the Student Health Service of DH would continue to monitor the changes of school children's eating habits and the trend of obesity rate, and conduct relevant research to review and improve the strategies and measures for promoting healthy eating. The Campaign was implemented in response to the rising trend of obesity among primary school children from 16.2% in the 1995-1996 academic year to 21.3% in the 2007-2008 academic year.

34. Ms Cyd HO said that DH should conduct a longitudinal study on school children participating in the Campaign to find out how the Campaign had changed their eating habits both in school and at home.

35. USFH advised that DH had commissioned the University of Hong Kong some two years ago to conduct a Child Health Survey to find out the eating habits of school children. Results of the survey would be released shortly. USFH further advised that the Centre for Food Safety of the Food and Environmental Hygiene Department had also commissioned the Chinese University of Hong Kong to conduct a Food Consumption Survey to collect food consumption data of the population, such as types of food intake, amounts of food intake and dietary practices. Ms Cyd HO requested the Administration to provide findings of these two surveys once they became available. USFH agreed.

Admin

Action

36. Ms Audrey EU said that the Campaign should also focus on the problem of underweight among youngsters.

37. USFH responded that the Campaign was aimed at promoting eating habits among school children, albeit more emphasis was placed on addressing obesity due to the rising trend of obesity among primary school children. USFH further said that students of all primary and secondary day schools were given an annual appointment to participate in the student health service provided by DH. The scope of service covered physical examination; screening for health problems related to growth, nutrition, blood pressure, vision, hearing, spine, sexual development, psychological health and behaviour; individual counselling and health education. Students found to have health problems would be referred to the special assessment centre or specialist clinics for detailed assessment and follow-up. Over 90% of primary school students and over 70% of secondary school students participated in the student health service.

38. Mr Albert CHAN said that apart from promoting eating habits, it was equally important to ensure that the physical and psychological well-being of school children were not undermined by faulty government policies. Mr CHAN suggested that this issue be included in the outstanding issues for discussion by the Panel. Members did not raise any queries.

V. Allocation of resources among hospital clusters by the Hospital Authority

(LC Paper Nos. CB(2)774/08-09(05) & (06))

39. USFH and Chief Executive, HA briefed members on a new "Pay for Performance" internal resource allocation system for funding hospital clusters by HA, details of which were set out in the Administration's paper (LC Paper No. CB(2) 774/08-09(05)).

40. Mr Albert CHAN said that for fairness, allocation of resources to hospital clusters should be based on the population of the region concerned. Mr CHAN asked how the new "Pay for Performance" system could help to address the present under-provision of funding to the New Territories West Cluster.

41. Mr Alan LEONG also asked whether the concern about the casemix approach would result in those under-provided hospitals, such as the United Christian Hospital (UCH), getting less funding was valid, as these hospitals were less endowed than other established hospitals in taking up complicated cases.

42. USFH responded that apart from allocating resources on the basis of the output and workload of hospitals, specific funding would be allocated to specific programmes and target areas. There were three key elements, namely,

Action

funding growth in targeted activities; funding for quality improvement programmes; and funding for technology advancement, service improvement and workforce supply. Details of these modifiers were set out in paragraph 8 of the Administration's paper.

43. Mr Albert CHAN requested the Administration to provide a paper setting out the amount of funding allocated/to be allocated to each of the seven hospital clusters this year/next year as well as the ratio of such funding per 1 000 population of individual hospital cluster. USFH undertook to provide the information after the release of the 2009-2010 Budget and the subsequent internal funding allocation by HA.

Admin

44. Mr Albert HO also requested the Administration to explain in writing on the reasons/justifications as to why some hospital clusters were under-provided vis-à-vis other hospital clusters with similar number of population and whether any actions would be taken to address such discrepancies, and if so, what they were. USFH agreed.

Admin

45. Mr Andrew CHENG shared the views that allocation of resources to hospital clusters should be based on population needs. Mr CHENG queried whether the implementation of the complicated new "Pay for Performance" system was to justify the high salaries paid to senior executives. Mr CHENG opined that the main reasons why allocation of resources among hospital clusters was uneven were due to insufficient funding to HA and the existence of fiefdoms among hospital clusters due to the reluctance of HA to rotate Cluster Chief Executives (CCEs) and HCEs.

46. USFH responded that the new funding mechanism would also take into account the services needs driven by demographic changes, with more refined assessment of the resource requirements through the adoption of the casemix approach which referred to a way of classifying the acute in-patients with similar healthcare needs into different groups, namely, Diagnosis Related Groups (DRGs) according to clinical diagnosis. The DRG system was an internationally-adopted patient classification system which enabled the generation of information on the volume as well as the mix of patients requiring treatment with different level of complexity in a hospital. In other words, in classifying patients into different DRGs, HA could properly measure hospitals' workload with the number of cases treated by the hospitals, adjusted by the complexity of the cases. By understanding the resource implication for each of the DRG, resources could then be fairly allocated to the hospitals on the basis of their number of patients and complexity of the cases. In addition, resources could be directed to specific service areas effectively by targeting funds to patients in specific DRG. As regards rotation of CCEs and HCEs, USFH said that this had been progressively taken forward by HA.

47. Ms Cyd HO pointed out that funding to HA was initially facility-based, which was later changed to population-based. To enable members to better

Action

Admin

understand the merits of the new "Pay for Performance" system, Ms HO requested the Administration to provide a paper setting out the pros and cons of the aforesaid three funding arrangements. USFH agreed.

48. Ms Cyd HO expressed concern about some general hospitals would turn into specialist hospitals as a result of the implementation of the new "Pay for Performance" system. USFH responded that there was no cause for such concern as the roles and functions of each hospital/hospital cluster were co-ordinated centrally by HA Head Office to ensure the best match of portfolios of public hospitals in a geographical region in terms of role delineation and service provision, the provision of hospital services in the region as well as the demographic structure of the region.

49. Mr Alan LEONG asked whether the new "Pay for Performance" system would replace the existing hospital clustering arrangements, and the timetable for expanding UCH to better meet the needs of people living in the Kowloon East region.

50. USFH responded that the new "Pay for Performance" system was only a new internal resource allocation system for funding hospital clusters and had no bearing on the hospital clustering arrangements. On the proposed capital project in UCH, USFH said that the Administration was forging ahead with the planning work.

51. Dr LEUNG Ka-lau said that HA should train clerical staff to do the clinical coding to alleviate the workload of frontline doctors, to prevent frontline doctors from deliberately classifying cases into more complicated DRGs in order to get more resources, and to ensure consistency in classifying the acute in-patients with similar healthcare needs into different DRGs across all hospitals.

52. Mr Vincent FANG said that using the casemix approach to allocate resources within HA might give rise to more disputes, as the classification of in-patients into different DRGs were decided by individual attending doctors concerned.

53. USFH responded that administrative staff would be assigned by HA to carry out verification and auditing of clinical coding, as was practised in overseas places. USFH further said that he was not worried that frontline doctors would deliberately classify cases into more complicated DRGs in order to get more resources as he firmly believed that frontline doctors would carry out their duties in a professional manner.

54. Dr PAN Pey-chyou said that resources allocated to each hospital cluster should be made public to facilitate public scrutiny. Dr PAN further said that HA management should have regard to the fact that the adoption of the casemix approach would add to the already heavy workload of frontline doctors in its

Action

manpower planning.

55. USFH responded that it was the established practice of HA to make public the resources allocated to each hospital cluster. USFH further said that the adoption of the casemix approach should not significantly increase the workload of frontline doctors, as classifying the in-patients into different DRGs, which was built on the International Classification of Diseases, merely required frontline doctors to take one step further to make the classification process more complete.

VI. Any other business

56. The Chairman sought members' view on holding a joint meeting with the Panel on Welfare Services to discuss the issue of employment assistance to ex-mentally ill persons. Members agreed.

> (*Post-meeting note:* As the issue falls mainly within the policy purview of the Panel on Manpower, it was agreed between the Chairmen of this Panel, the Panel on Welfare Services and the Panel on Manpower that the issue be followed up by the Panel on Manpower. Members of this Panel and the Panel on Welfare Services will be invited to join the discussion of the issue once a meeting date has been confirmed by the Panel on Manpower.)

57. There being no other business, the meeting ended at 10:47 am.

Council Business Division 2
Legislative Council Secretariat
2 March 2009