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Legislative Council

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LC Paper No. CB(2)1248/08-09
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 9 March 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 Fred LI Wah-ming, JP 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 CHAN Hak-kan Dr Hon PAN Pey-chyou
Members attending	:	Hon CHAN Kin-por, JP Dr Hon Samson TAM Wai-ho, JP
Members absent	:	Hon Cyd HO Sau-lan Hon IP Kwok-him, GBS, JP
Public Officers attending	:	Item IV Dr York CHOW, SBS, JP Secretary for Food and Health Ms Sandra LEE, JP Permanent Secretary for Food and Health (Health) Mr Thomas CHAN Deputy Secretary for Food and Health (Health) 2

		Dr Ngai Tsueng CHEUNG Consultant (eHealth) Mr Jeremy R.GODFREY Government Chief Information Officer, Office of the Government Chief Information Officer <u>Items IV-VI</u> Professor Gabriel M LEUNG, JP Under Secretary for Food and Health <u>Items V- VI</u> Miss Gloria LO Principal Assistant Secretary for Food and Health (Health) Mr Shane SOLOMON Chief Executive Hospital Authority Dr P Y LEUNG, JP Director (Quality & Safety) Hospital Authority <u>Item VI</u> Dr S K CHOW Deputising Hospital Chief Executive, Pamela Youde Nethersole Eastern Hospital Hospital Authority Dr C C LAU Chairman, Investigation Panel on Missing Baby Body, Pamela Youde Nethersole Eastern Hospital 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

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I. Confirmation of minutes
(LC Paper No. CB(2)995/08-09)

The minutes of meeting held on 9 February 2009 were confirmed.

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

2. Members noted the following papers provided by the Administration issued since the last meeting -

(a) Information paper on "Inclusion of pneumococcal conjugate vaccine in the Childhood Immunisation Programme" (LC Paper No. CB(2)1007/08-09(01)); and

(b) Information paper on "Update on prevention and control measures on human avian influenza infection and pandemic preparedness" (LC Paper No. CB(2)1007/08-09(02)).

III. Items for discussion at the next meeting
(LC Paper Nos. CB(2)1006/08-09(01) & (02))

3. Members agreed to discuss the following items at the next meeting scheduled for 6 April 2009 -

(a) Implementation of the smoking offence fixed penalty system;

(b) Report on findings of technical feasibility study on smoking room; and

(c) Redevelopment of Caritas Medical Centre, Phase Two.

4. Members further agreed to hold a special meeting to discuss the following items -

(a) Inclusion of pneumococcal conjugate vaccine in the Childhood Immunisation Programme proposed by Dr LEUNG Ka-lau; and

(b) Incident on fungal contamination of Allopurinol proposed by Ms Audrey EU.

(*Post-meeting note*: The special meeting was held on 31 March 2009 and item (b) was revised to "Regulation and control of pharmaceutical products in Hong Kong".)

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IV. Development of a territory-wide electronic healthcare record sharing system

(LC Paper Nos. CB(2)1006/08-09(03)(Revised) to (06), CB(2)1028/08-09(01) to (21), CB(2)1037/08-09(01) to (07) and CB(2)1055/08-09(01) to (09))

5. Secretary for Food and Health (SFH) briefed Members on the Government's proposal to develop a territory-wide patient-oriented electronic health record (eHR) sharing system, as well as the proposal to the Finance Committee (FC) and its Establishment Subcommittee (ESC) in May/June 2009 for funding and staffing resources to take the proposed programme forward, details of which were set out in the Administration's paper ((LC Paper No. CB(2)1006/08-09(03)(Revised)). Deputy Secretary for Food and Health (Health) 2 then took Members through the eHR development programme with the aid of powerpoint, details of which were set out in the presentation material tabled at the meeting (LC Paper No. CB(2) 1072/08-09/(01)).

6. Members noted that all submissions received were supportive of the Government's proposal to develop a territory-wide eHR sharing system (LC Paper Nos. CB(2)1006/08-09(04) to (05), CB(2)1028/08-09(01) to (20), CB(2)1037/08-09(01) to (07) and CB(2)1055/08-09(01) to (09)).

Legal, privacy and security issues

7. Whilst expressing supporting for the eHR sharing system, Mr CHAN Hak-kan asked about the role of the Office of the Privacy Commissioner for Personal Data (PCO) and the legal framework to safeguard data privacy and security.

8. Mr Albert CHAN opined that it should be made a criminal offence for any person who knowingly or recklessly, without the consent of patients, obtained or disclosed the patients' information stored in the eHR sharing system or subsequently sold the information so obtained for profits.

9. SFH responded that the Administration accorded paramount importance to data privacy and system integrity and security of the eHR sharing system. To this end, PCO had been invited to participate in the Working Group on Legal, Privacy and Security Issues under the Steering Committee on eHR Sharing (the Steering Committee) to advise on protection of personal data privacy in general, including compliance with the Personal Data (Privacy) Ordinance (Cap. 486) and development of long-term legal framework. SFH further said that the Administration would take ample measures in terms of technical design and operation to safeguard the data privacy and security of the eHR sharing system, and the system would be leveraged upon the Hospital Authority (HA)'s expertise and know-how in the development of its Clinical Management System (CMS) since 1995 for storing and retrieving patients' medical records.

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10. On giving legal protection to data privacy and security, SFH said that legislative work would be needed and the proposed eHealth Record Office (the eHR Office) would proceed with studies and preparatory work in this regard. SFH added that the Steering Committee had surveyed the current legislative provisions applicable to personal health data, and recognised the need to address a number of legal issues including record ownership and copyright and to explore the long-term legal framework for safeguarding the privacy and security of such personal health data, having regard to the context of the eHR sharing system. The work to address these legal issues and develop the necessary legal framework would proceed in tandem with the development of the eHR sharing infrastructure, taking into account experience of similar legislative developments in overseas economies, to meet the needs of the future eHR sharing infrastructure and the aspirations of the community.

11. Mr CHAN Hak-kan remarked that although it might be technically feasible to prevent unauthorised access to the eHR sharing system, there was no way to prevent any authorised person from downloading patients' information from the system for unauthorised disclosure.

12. SFH pointed out that similar to CMS in HA, the eHR sharing system would be designed to log records of who and when had accessed the system and the types of data that had been accessed/downloaded. Legal sanctions for unauthorised access and disclosure would also be considered as part of the legal framework to be formulated.

13. Dr LEUNG Ka-lau asked whether health-related and medical data of patients recorded in a electronic format could be used as evidence in legal proceedings. If that was the case, this would increase the already heavy workload of frontline staff at HA.

14. SFH responded that it remained healthcare professionals' duties to maintain patients' records and to produce them as evidence in legal proceedings, regardless of whether they were recorded in a paper or electronic format. SFH further said that the implementation of the eHR sharing system should not create additional workload to HA frontline staff as CMS would continue to be used in HA after the implementation of the eHR sharing system.

15. Dr LEUNG expressed concern that medical data of patients recorded in electronic format could be used as evidence in legal proceedings, as radiological images displayed on computer monitor were far from clear for doctors to make medical judgements.

16. SFH responded that radiological images should not be a cause for such concern as they would invariably come with radiologist reports. Moreover, there were more specialised computer monitors with higher resolution, than those usually located at hospital wards for viewing of radiological images recorded in electronic format, which would be up to the level of detail required for radiologists.

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Participation in eHR sharing

17. Mr CHAN Hak-kan expressed concern that private doctors in solo practice might be disinterested in participating eHR sharing, as to do so would inevitably add to their overhead.

18. SFH responded that the Hong Kong Medical Association and the Hong Kong Doctors Union had been participating in the Steering Committee and were supportive of eHR development through a Government-led and co-ordinated programme with measures to facilitate the adoption of eHR by private hospitals, doctors and other healthcare providers. SFH pointed out that eHR sharing would benefit private doctors in making specialist or hospital referrals for their patients, amongst others. The sharing platform would also facilitate private doctors participating in various public-private partnership schemes, including voucher schemes for subsidised healthcare.

19. Mr CHAN Kin-por said that willingness of private doctors to participate in eHR sharing was crucial to the success of the project.

20. SFH responded that the Administration had been exchanging views with private doctors on eHR sharing, and their feedback was generally very positive. The proposed eHR programme reflected the consensus reached by the medical professions, which emphasised the need for the Government to take the lead in investing and co-ordinating the eHR development. Mr Andrew CHENG requested the Administration to provide evidence that private doctors and clinics were willing to participate in eHR sharing and bear responsibility for their own hardware and recurrent costs.

21. Mr Albert HO asked -

(a) whether private healthcare providers who chose not to participate in eHR sharing would run the risk of being sued for professional negligence by their patients; and

(b) whether participating healthcare providers would be charged a fee and how much costs they would need to bear for using the eHR sharing system.

22. SFH responded that participation in eHR sharing was not compulsory for both patients and healthcare providers. Regarding Mr HO's second question, SFH said that the Government would invest in developing and operating the infrastructure and had yet to calculate the hardware and recurrent costs that healthcare providers would need to bear to adopt their own electronic system and connect to the sharing platform. No decision had been taken to charge participating healthcare providers for using the eHR sharing system.

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Capital costs for eHR development

23. Ms Audrey EU requested a breakdown of the estimated capital costs of $702 million for the First Stage eHR Development Programme from 2009-2010 to 2013-2014.

24. SFH advised that the breakdown was set out at Annex E of the Administration's paper. SFH further advised that although the total investment for developing the eHR sharing system, including the Government's funding for both the eHR sharing infrastructure and HA's CMS (both existing and future upgrading), from 2009-2010 to 2018-2019 was estimated to be about $1,124 million, the cost on a per capita level was considerably lower than that for developing similar projects in overseas countries. For instance, similar initiatives overseas carried a per capita cost in the range of $2,300 to $2,800 in the United Kingdom (UK), Canada and the United States (US). Meanwhile, counting only investment by the public sector in developing the eHR sharing system, it was estimated that the eHR sharing system would cost around some $900 per capita in Hong Kong. With the Government taking the lead in developing the sharing infrastructure and making systems and know-how in the public sector available, it was expected that investment by the private sector in their own electronic medical/patient record systems to be of a much smaller scale, making the total investment well below those overseas.

25. Government Chief Information Officer (GCIO) supplemented that it was estimated that up to 70% of the project capital budget would be spent on purchasing hardware and software, hiring contractors and outsourcing certain work to the private sector, whereas about 30% of the project capital budget would be apportioned to HA to cover the costs of its information technology (IT) staff and other experts.

26. GCIO further said that experience from the development of CMS in HA as well as development of eHR sharing systems overseas suggested that successful development of the eHR sharing system should proceed on a building block approach, i.e. to break down the eHR sharing system into individual components, to develop modules under each component step-by-step with pilots as necessary, to involve user feedback in designing and developing modules, to gradually extend proven modules with add-on scope and functionalities, and to bring together modules to build the components that support the sharing system. Such a strategy had proven to work well for the development of CMS in HA, and would avoid the big-bang approach that had challenged eHR development in some overseas countries.

27. Referring to the comparison made by SFH in paragraph 24 above with regard to the cost for developing an eHR sharing system on a per capita level, Mr Albert HO asked whether the infrastructure of the eHR sharing system in Hong Kong was similar to that of the eHR initiatives in UK, Canada and US.

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28. SFH responded that the comparison was drawn from known or pledged investments in overseas eHR initiatives, and had no bearing on the infrastructure of these initiatives. For instance, the eHR initiatives in UK and Canada were in the developing stage and had yet to cover all levels of healthcare from hospitals to clinics or nation-wide, whereas the eHR sharing systems in US were more developed but for a limited scope of healthcare providers such as those covered by the same insurance or healthcare scheme. SFH further said that the eHR sharing system in Hong Kong was already more advanced than similar systems around the world in that patients' records encompassed such medical data as laboratory test results and radiological images and were already tightly integrated within public hospitals and clinics and used by clinicians and other healthcare professionals for delivery of healthcare. When the system was expanded to cover the private hospitals and clinics in future, Hong Kong would be way ahead of other cities on eHR.

29. Mr Albert CHAN remained of the view that spending some $1,124 million on eHR development was on the high side. Mr Andrew CHENG also said that whilst he recognised that eHR development was integral to healthcare reform, the benefits to patients, if realised, were at best remote. Mr CHENG urged the Administration to allocate additional funds to HA to enable it to include drugs proven to be of significant benefits but extremely expensive to provide as part of HA's subsidised services.

30. SFH responded that the some $1,124 million capital costs for eHR development, to be spread over a 10-year period, would only constitute around 0.2% of the annual total health expenditure at some $60 to $70 billion. This was considerably lower than the some 3% to 5% of the budget generally set aside by major organisations and companies in the private sector on IT systems.

31. SFH further said that a one-off grant of $1 billion had been injected into the Samaritan Fund to include more self-financed item drugs, amongst others, for the coming three years. Moreover, with the increase to its recurrent subvention by about $870 million every year over the next three financial years, HA should have more resources to improve patients' care, including its Drug Formulary.

Staffing for the eHealth Record Office

32. Ms Audrey EU asked about the justification for creating four directorate posts in the proposed eHR Office.

33. SFH referred members to Annex F to the Administration's paper detailing the justification for the proposed creation of four directorate posts in the eHR Office, amongst others. SFH further said that given the complex and multi-faceted development programme of the eHR sharing system, including policy, legal, privacy and security issues, as well as the need for engagement of stakeholders and the public, it was necessary to set up the proposed eHR Office to lead, co-ordinate and implement the initiative in both the public and private

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sectors. The Administration had critically examined the possible redeployment of other existing directorate officers under the Permanent Secretary for Food and Health (Health) to take on the work of the proposed directorate posts for the proposed eHR Office. However, the conclusion was that it was not operationally feasible without affecting the quality of their work as all the existing directorate officers were fully engaged in their respective duties, including other ongoing healthcare reform initiatives such as primary care reform, public-private partnership projects and development of centres of excellence and private hospitals.

34. Mr Albert CHAN criticised that the proposed creation of four directorate posts in the eHR Office was again a case of "fattening the top and thinning the bottom" by the Administration.

35. SFH responded that apart from the proposed four directorate staff, the proposed eHR Office would be supported by 16 non-directorate civil servants to provide policy steer, co-ordination and management of the overall programme, including handling of legislative and privacy issues as well as engaging the stakeholders in the healthcare and IT sectors and the public. The proposed eHR Office would also be supported by dedicated eHR teams from HA's IT Services Unit and the Department of Health which would provide the technical support on IT development. It was envisaged that the teams involved in eHR development and related projects would need to engage up to a maximum of 300 staff comprising mainly IT professionals and support staff.

36. Dr PAN Pey-chyou noted from paragraphs 17 and 18 of Annex F of the Administration's paper that the full annual average staff cost for the proposed four directorate posts and the 16 non-directorate posts in the proposed eHR Office would amount to about $18 million. As the eHR development would take some 10 years to complete, Dr PAN asked whether this meant that the financial implications with regard to staffing for the proposed eHR Office would come to about $180 million in total.

37. Permanent Secretary for Food and Health (Health) advised that this might not be the case as two of the proposed directorate posts, i.e. the Administrative Officer Staff Grade B (D3) and the Administrative Officer Staff Grade C (D4), were supernumerary posts for four years. The continued need for these supernumerary posts would be reviewed in due course having regard to the overall development of the system.

Conclusion

38. In closing, the Chairman said that Members in principle supported the eHR programme. Based on the views expressed by Members at the meeting, the Chairman requested the Administration to provide the following information in writing before seeking the support of FC and ESC for funding and staffing resources to take the eHR programme forward -

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(a) detailed breakdown of the estimated capital costs of $702 million for the First Stage eHR Development Programme;

(b) timetable on putting in place a legal framework for safeguarding the data privacy and security of the eHR sharing system; and

(c) estimated capital and recurrent costs to be borne by private healthcare providers participating in the eHR sharing system.

V. Update on the Caritas Medical Centre Incident
(LC Paper Nos. CB(2)1006/08-09(07), CB(2)1028/08-09(22) and CB(2)591/08-09(03))

VI. Update on the Pamela Youde Nethersole Eastern Hospital Mortuary Incident
(LC Paper Nos. CB(2)1006/08-09(08), CB(2)1028/08-09(23), CB(2)607/08-09(01) and CB(2)1017/08-09(01))

39. Due to time constraint, the Chairman suggested and members agreed to discuss the above two items together.

40. Mr Albert CHAN requested HA to make public the report by the Special Review Committee set up by HA to determine the appropriate human resources actions against the staff involved in the Caritas Medical Centre (CMC) incident. Mr CHAN expressed dissatisfaction that no senior management staff at HA Head Office was held accountable for the CMC incident, and strongly reprimanded the Food and Health Bureau (FHB) for letting this happened.

41. Under Secretary for Food and Health (USFH) responded that FHB was very concerned about the CMC incident. Immediately following the CMC incident, SFH instructed HA to review the incident and relevant issues, including the handling procedures and guidelines of public seeking assistance by hospitals as well as emergency equipment and training, to prevent recurrence of similar incident. Upon receipt of HA's investigation report on the incident, SFH further instructed HA to put in place appropriate improvement measures and report to FHB on the progress regularly.

42. Chief Executive, HA (CE, HA) assured members that nothing was hidden with regard to the responsibilities of the staff involved in the CMC incident. The reason for not releasing the whole report of the Special Review Committee was because the report was purely a disciplinary hearing report and HA did not release disciplinary hearing reports.

43. Mr Andrew CHENG said that the reason why the work of the Special Review Committee lacked credibility was because it was set up by HA and its members were HA staff. Mr CHENG urged the Administration to set up an independent office to handle adverse medical incidents and medical complaints.

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44. USFH responded that the Administration did not see the need to create another tier to manage medical complaints. HA had set up an effective two-tier complaint system for the proper handling of medical complaints. All views or initial complaints about hospital services would first be handled and responded by the hospital directly. If the complainant wished to put forward further views or was not satisfied with the handling/outcome of his/her complaint, he/she could file an appeal with the Public Complaints Committee (PCC) of HA. PCC was comprised of members from different sectors of the community and responsible for considering and deciding on all appeal cases independently. Members of PCC were not HA employees, and PCC was not affiliated to any hospital or operational departments/service units. To enhance its transparency, PCC regularly reported its work to the public and released statistical data on the complaints received, including the types and findings of the complaint cases. Apart from HA's complaint system, members of the public might also lodge their complaints with other organisations such as the Medical Council of Hong Kong.

45. USFH further said that to improve service quality, reduce the risk to patients and prevent the recurrence of medical incidents, HA had put in place a mechanism and guidelines for medical staff to report medical incidents and take follow-up actions properly. Under the existing mechanism, hospital staff would make timely reports of medical incident to the hospital/cluster management and HA Head Office through HA's internal electronic system, namely, the Advanced Incident Reporting System. HA had also been promoting a patient-centred and learning culture amongst its staff, under which staff were encouraged to report a medical incident in a timely and open manner, and share their experience in handling medical incidents. In addition, HA had since October 2007 implemented a Sentinel Event Policy to strengthen the reporting, management and monitoring of sentinel events in public hospitals, so as to further enhance service quality and patient safety. To better meet the rising expectation of the public and to strengthen public's confidence in HA's services, two new initiatives, viz: a Patient Satisfactory Survey and a pilot project of hospital accreditation, were under active planning.

46. Mr Andrew CHENG asked why the Administration did not consider setting up an investigation panel to investigate the CMC incident and the Pamela Youde Nethersole Eastern Hospital (PYNEH) incident respectively was creating another tier to handle medical incidents.

47. USFH responded that in view of the gravity of the CMC incident and the PYNEH incident, it was necessary to demonstrate to the public that full investigation and review of the incidents would be carried out in a fair and transparent manner through the establishment of independent investigation panels. For instance, the Investigation Panel on the PYNEH incident comprised two HA staff, i.e. the Deputy Hospital Executive and Chief of Service (Accident and Emergency), PYNEH and Hospital Chief Executive, Ruttonjee & Tang Shiu Kin Hospital and Tung Wah Eastern Hospital, and three non-HA staff

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including a member of the PYNEH Hospital Governing Committee, a member of PCC and a representative of patient group.

48. Dr PAN Pey-chyou noted that following the PYNEH mortuary incident, HA would conduct a comprehensive review on mortuary management and explore measures to strengthen mortuary operation. Dr PAN asked whether frontline mortuary staff would be engaged in the review. Dr PAN further asked how HA would ensure full compliance of the working guidelines by mortuary staff.

49. Director (Quality & Safety), HA (D(Q&F), HA) replied in the positive to Dr PAN's first question. As regards Dr PAN's second question, D(Q&F), HA said that daily verification of deceased bodies against mortuary records had been carried out; CCTV was being installed in all HA mortuaries for better monitoring; and a half-yearly audit on compliance with established standard operation procedures would be conducted.

50. The Chairman asked about the criteria adopted by HA in determining the disciplinary actions against the staff concerned in the CMC and PYNEH incidents.

51. CE, HA responded that in determining disciplinary actions against staff, the general principle was whether the actions that led to the incidents were attributed by management or by the staff who had acted independently of the management.

52. In closing, the Chairman said that HA should learn from the incidents to prevent similar incidents from recurring.

53. There being no other business, the meeting ended at 10:35 am.

Council Business Division 2
Legislative Council Secretariat
3 April 2009