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Legislative Council

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LC Paper No. CB(2)2385/08-09
(The minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 8 June 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 Cyd HO Sau-lan Hon CHAN Hak-kan Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou
Member attending	:	Hon WONG Kwok-hing, MH
Public Officers attending	:	Items IV-VI Professor Gabriel M LEUNG, JP Under Secretary for Food and Health Items V-VI Miss Gloria LO Principal Assistant Secretary for Food and Health (Health)2 Dr CHEUNG Wai-lun Director (Cluster Services) Hospital Authority

Item IV

Mr Bruno LUK
Principal Assistant Secretary for Food and Health (Health)3

Dr Emily LEUNG
Principal Medical Officer
Department of Health

Dr C H LEONG, GBS, JP
Chairperson, Council on Human Reproductive Technology

Item V

Dr Su Vui LO
Director (Strategy & Planning)
Hospital Authority

Dr Joseph LUI
Deputy Hospital Chief Executive,
Princess Margaret Hospital
Hospital Authority

Mr Donald LI
Deputising Chief Manager (Capital Planning) Hospital Authority

Item VI

Dr Beatrice CHENG
Chief Manager (Cluster Performance)
Hospital Authority

Ms Anna LEE
Chief Pharmacist
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)1739/08-09)

The minutes of meeting held on 20 April 2009 were confirmed.

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

2. There was no information paper issued since the last meeting.

III. Items for discussion at the next meeting
(LC Paper Nos. CB(2)1740/08-09(01) and (02))

3. Members agreed to discuss the following items at the next meeting scheduled for 13 July 2009 -

(a) Reprovisioning of Yaumatei Specialist Clinic at Queen Elizabeth Hospital; and

(b) Update on the prevention and control of Human Swine Influenza infection in Hong Kong.

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4. The Chairman requested and Under Secretary for Food and Health (USFH) agreed to provide written responses to items 2, 4, 6 and 8 on the list of follow-up actions (LC Paper No. CB(2)1740/08-09(02)) before the expiry of the current legislative session as far as practicable.

IV. Progress of licensing under the Human Reproductive Technology Ordinance
(LC Paper Nos. CB(2)1740/08-09(06) and (07))

5. USFH briefed members on the progress of licensing under the Human Reproductive Technology Ordinance (HRTO) (Cap. 561) by the Council on Human Reproductive Technology (CHRT), details of which were set out in the Administration's paper (LC Paper No. CB(2)1740/08-09(06)).

6. Noting that medical services were one of the six economic areas identified by the Task Force on Economic Challenges (TFEC) for further development to benefit Hong Kong's economy in the medium to long term, Ms Audrey EU asked whether Hong Kong's strength in reproductive technology (RT) would be tapped in this regard. Ms EU said that she did not wish to see RT services being turned into new business opportunities.

7. USFH responded that TFEC had yet to come up with its recommendations for promoting the development of the six economic areas, to which the Administration would consider which, and if so, how these

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recommendations could be taken forward. Chairperson, CHRT pointed out that the broad principle of HRTO was neither to promote nor completely prohibit the practice of RT. Specifically, section 15(5) of HRTO stipulated that provision of RT services should be limited to infertile married couples.

8. Dr PAN Pey-chyou asked whether human embryos could be used in Hong Kong for conducting stem cell research.

9. USFH responded that section 15(1) of HRTO prohibited creation of embryos for the purpose of research and cloning of embryos, human embryonic stem cell research could only be conducted in Hong Kong if the embryos used were donated or imported from overseas. To his understanding, only the two teaching hospitals in Hong Kong were presently conducting fundamental human embryonic stem cell research.

10. Dr PAN Pey-chyou noted that CHRT might issue four types of licences, namely, (i) treatment licence; (ii) artificial insemination by husband (AIH) licence; (iii) storage licence; and (iv) research licence. Dr PAN asked whether an applicant could apply more than one type of these licences. Chairperson, CHRT replied in the positive, and undertook to provide a breakdown of the types of licences issued to applicants after the meeting.

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11. Mr Albert CHAN was of the view as the ethical issues involved in RT activities would change over time, the various restrictions set out under HRTO should be kept under constant review to ensure that persons in need would not be deprived of access to RT services. He further suggested that consideration should be given to amending HRTO to allow single persons to have babies through surrogacy arrangements.

12. Chairperson, CHRT advised that it was necessary to strike a balance between ethical consideration and the rapid development of RT. In view of the complex social, moral, ethical and legal issues involved in RT activities, a multi-disciplinary approach was adopted by the CHRT to ensure the RT service providers and researchers paid due respect to human life, the role of the family, the rights of service users and the welfare of the children born as a result of the use of the technology. At present, no person shall provide a RT procedure to persons who were not parties to a marriage.

13. Noting that CHRT was established in accordance with HRTO in 2001, Ms Cyd HO asked about the reason for taking CHRT some six years to come up with the licensing system for RT service providers and embryo researchers set out in the Human Reproductive Technology (Licensing) Regulation (Cap. 561A).

14. Chairperson, CHRT said that the main reason why it took some six years to come up with the licensing system was due to the fact that RT was a fairly new concept in Hong Kong. The RT activities, such as surrogacy arrangements, also involved complex social, moral and ethical issues. To prepare for the

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implementation of a licensing system in Hong Kong, a number of members of CHRT went overseas to study similar licensing systems. Two overseas inspectors from the Human Fertilisation and Embryology Authority of the United Kingdom had also been invited to Hong Kong in November 2007 for exchanges and conducting of a training workshop for the local inspectors with a view to assisting CHRT in performing the licensing work. Chairperson, CHRT further said that a Code of Practice on Reproductive Technology & Embyro Research (CoP) had been drawn up by CHRT in 2002 to provide guidance for practitioners and researchers in the field. Although a failure to comply with CoP did not in itself result in liabilities to any proceedings, CHRT, which was the licensing authority for RT services and embryo research, would take into account any failure to observe the provisions of CoP when considering granting, renewal, variation, suspension or revocation of licences.

15. In response to Ms Cyd HO's enquiry about whether RT services were available in the public sector to let infertile married couples to access the services at affordable prices, Chairperson, CHRT said that RT services were presently provided by the Queen Mary Hospital and the Prince of Wales Hospital.

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16. Ms Cyd HO asked whether clear research guidelines had been drawn up for compliance by embryo researchers. USFH replied in the positive, and undertook to provide after the meeting the list of licensees with research licence.

17. Mr Alan LEONG said that in accordance with section 47 of HRTO, existing RT service providers and embryo researchers had a transitional period of six months after commencement of the relevant provisions on 1 August 2007 for applying for a licence. He noted that after the expiry of the transitional period which ended on 31 January 2008, only one application for new licence was received by CHRT in November 2008. He was concerned about whether this was due to the stringent threshold imposed by CHRT.

18. USFH said that there was no cause for such concern, and pointed out that 57 out of 63 existing service providers and embryo researchers had submitted application for license under the transitional arrangements, which implied an application rate of about 90%. As at 27 May 2009, CHRT had received a total of 59 applications for licences and 54 licences had been issued. At the request of Mr LEONG, USFH undertook to provide the number of licence applications received so far and the number of licences issued by CHRT.

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19. Dr LEUNG Ka-lau asked whether medical practitioners in the discipline of obstetrics and gynaecology were required to apply to CHRT for a licence to provide reproductive treatment at individual hospitals. He further enquired about the requirement on qualification and experience for the person responsible and the licensee.

20. Responding to Dr LEUNG's first question, Chairperson, CHRT said that licences were issued to the premises for carrying out the RT activities, instead of individuals. It should however be noted that medical practitioners concerned

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should follow the codes of practice and professional ethics of their individual disciplines.

21. As regards Dr LEUNG's second question, Chairperson, CHRT said that under HRTO, person responsible referred to the individual specified in the licence as the individual under whose supervision the activities authorised by the licence were carried out. The licensee referred to the holder of the licence and could be a body corporate. While the person responsible was not required to meet any requirement on qualification and experience, he/she should ensure, inter alia, the professional staff at the RT centres were well-qualified by training and experience and suitable to take part in the relevant RT activities.

V. North Lantau Hospital project – phase one
(LC Paper No. CB(2)1740/08-09(03))

22. USFH briefed members on the proposed phase one development of the North Lantau Hospital (NLH) Project, details of which were set out in the Administration's paper (LC Paper No. CB(2)1740/08-09(03)).

23. Dr LEUNG Ka-lau noted that subject to the support of the Panel and the funding approval by the Finance Committee (FC) in December 2009, the construction works for phase one development of NLH Project would complete by the end of 2012. Holding the view that the demand for hospital services in Tin Shui Wai (TSW) was by no means less than that of the Lantau Island, he asked why the construction works for TSW hospital were scheduled to commence in 2011 for completion in 2015.

24. USFH responded that the preliminary planning for the construction of NLH had been embarked as early as 2004. As regards the TSW hospital, two possible sites had been identified and the Yuen Long District Council (DC) had been consulted on the proposed project scope and the proposed site for the hospital in March 2009. The Administration was currently conducting detailed technical assessments for the project and would further consult the Yuen Long DC on the proposed hospital site after completion of the relevant assessments. The plan was to seek funding approval from FC in 2010 with a view to commencing the project in 2011-2012 for completion in 2014-2015.

25. Dr PAN Pey-chyou said that the Kwoloon West (KW) cluster to which NLH belonged was at present the largest cluster in the Hospital Authority (HA), with a catchment population estimated to be more than triple that of the smaller clusters. He was concerned that the construction of the North Lantau Hospital would make KW cluster even more cumbersome.

26. USFH said that according to the 2006 Population By-census conducted by the Census and Statistics Department, the resident population in Lantau Island was projected to be around 123 100 by 2015. The relatively small population of Lantau would not exert much pressure on the KW cluster.

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Director (Cluster Services), HA (Director (CS), HA) pointed out that the reason why public hospital services for North Lantau were covered by the KW cluster was due to the fact that the acute hospital closest to North Lantau by land transport was the Princess Margaret Hospital (PMH). PMH had also been designated as the first hospital for receiving victims in case of disasters occurred at the Hong Kong International Airport (HKIA) located at Chek Lap Kok of North Lantau. HA would keep the cluster arrangements under constant review.

27. Ms Cyd HO asked whether the capacity of NLH would be able to handle disasters with massive casualties, given that HKIA was situated in North Lantau and the Hong Kong-Zhunhai-Macao Bridge would land on North West Lantau. Dr LEUNG Ka-lau enquired whether NLH would also serve as a trauma centre and provide neurosurgery service for victims of airport disasters.

28. Director (CS), HA said that in the event of civil disasters, acute hospitals would operate in networks with support to each other and pre-hospital triage would be made in accordance with established protocols. For disasters occurred at HKIA or in North Lantau, PMH was the major receiving trauma centre to provide tertiary medical care to victims sent by land transport. The Tuen Mun Hospital (TMH) was the receiving hospital for victims sent by sea transport. Victims would also be sent by air transport to TMH or the Pamela Youde Nethersole Eastern Hospital where necessary. In view of NLH's close proximity to HKIA and other areas in the Lantau Island, it would be responsible for dispatching medical teams to incident sites to provide urgent treatment as well as receiving minor injury cases. However, the specialty of neurosurgery would not be included in the scope of services to be provided by NLH as it was not an acute tertiary hospital. In response to Ms HO's further enquiry, Director (CS), HA said that the size, facilities and manpower of the Accident and Emergency (A&E) Department of NLH were better than other HA hospitals of similar scale to build up its surge capacity in dealing with emergency crisis.

29. Noting that the Islands DC had given its support to NLH Project in April 2008, Mr WONG Kwok-hing asked why it had taken the Administration more than one year to put forward the proposal to the Panel for consideration. He further asked why the funding proposal for the project could not be put forth to FC for consideration in the current or at the beginning of the next legislative session so as to expedite the construction of NLH but have to wait until December 2009.

30. USFH advised that the site in Tung Chung Areas 22 and 25 reserved for the NLH project was originally zoned "Residential" area. It was therefore necessary to obtain the approval of the Town Planning Board (TPB) for re-zoning the site as "Government, Institution or Community" area where hospital use was always permitted. Having consulted and secured the support of the Islands DC in April 2008, application for re-zoning had been submitted to TPB in May 2008. The application was approved in April 2009 and arrangement had then been made to consult the Panel on the proposal. To expedite the construction of phase one of NLH, the Administration had in parallel conducted

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a pre-qualification exercise and had issued invitation for tenders to the pre-qualified tenderers in April 2009. The reason for seeking funding approval from FC in December 2009 was to have a more accurate project estimate based on the return of tender price. Such an arrangement would not delay the phase one of the project, which was targeted for completion by the end of 2012.

31. Mr WONG Kwok-hing said that at present, Tung Chung residents in urgent medical needs late at night had to seek treatment from the A&E Department of PMH, which required some 30 minutes travelling time to reach. In the light of this, he demanded HA to review the "special evening out-patient service" (10:00 pm to 11:45 pm) currently provided in Tung Chung on a trial basis, with a view to providing round-the-clock medical service or at least maintaining the late evening service until the commissioning of service of NLH by the end of 2012.

32. USFH said that since the introduction of the "special evening out-patient service" from July 2007 and up to April 2009, the average number of patients seeking consultations was 2.26 per day. The Administration considered at this stage that the "special evening out-patient service" could meet the medical needs of the Tung Chung community and thus did not see a need for extending the operating hours of the clinic to 24 hours a day. USFH added that the Administration would continue to closely monitor the medical services in Tung Chung in collaboration with HA and make appropriate improvements as necessary. There was no plan to discontinue the provision of the "special evening out-patient service" for the time being.

33. Deputy Hospital Chief Executive of PMH, HA supplemented that most patients seeking late evening consultations were non-urgent cases and only 6.67% of the attendees were required to transfer to the A&E Department for treatment. The statistics of HA also indicated that some 20% of the operating hours for the "special evening out-patient service" recorded zero cases.

34. Mr Albert CHAN was concerned about the scope of specialist out-patient services and primary care services to be provided by NLH, as Tung Chung residents with chronic disease were now required to travel a long distance to attend other hospitals in the KW cluster for regular follow-up consultation.

35. USFH responded that the specialties initially planned to be covered by NLH's specialist out-patient clinics included medicine, surgery, gynaecology, paediatrics, orthopaedics and traumatology as well as psychiatry. There would also be eight primary care clinic suites at NLH to provide primary curative care, screening and assessment of medical conditions. The day rehabilitation centre would also provide comprehensive integrated rehabilitation and allied health services to chronic patients. It should, however, be pointed out that NLH would be a community hospital providing primary and a selected range of specialist services. Hence, the range of specialist out-patient services to be provided by NLH would not be as comprehensive as an acute regional hospital such as PMH.

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36. Mr WONG Kwok-hing requested the Administration to provide Chinese medicine out-patient services at NLH. USFH responded that it was the Administration's plan to set up public Chinese medicine clinics (CMCs) in each of the 18 districts to enhance Chinese medicine service in the public healthcare system. There were 14 public CMCs at present.

37. Mr WONG Kwok hing enquired whether the work to explore the introduction of public-private-partnership (PPP) for the private sector to provide other medical facilities and services in the available area in addition to the 170 beds provided by the Government under phase two would proceed in tandem with the construction works for phase one of the NLH project.

38. USFH said that a site with 3 hectares comprising Tung Chung Areas 13, 22 and 25 had been reserved for the development of phase two to cater for the service needs of Lantau Island in the longer term. The Administration would explore the feasibility of introducing PPP for the development of phase two, which would proceed separately from phase one.

39. In response to the Chairman's enquiry as to whether the Administration would ensure that sufficient manpower could be made available for NLH upon its commencement of operation, USFH replied in the affirmative.

40. In closing, the Chairman said that the Panel was supportive of the proposed phase one development of the NLH project.

VI. Updates on the Drug Formulary of the Hospital Authority

(LC Paper Nos. CB(2)1740/08-09(04) to (05))

41. USFH briefed members on the latest developments of the HA Drug Formulary (the Formulary), details of which were set out in the Administration's paper (LC Paper No. CB(2)1740/08-09(04)).

Introduction of new drugs in the Formulary

42. Dr PAN Pey-chyou enquired about the evaluation criteria for the introduction of new drugs in the Formulary.

43. Director (Cluster Services), HA (Director (CS), HA) said that the introduction of new drugs into the Formulary was regularly conducted by HA Drug Advisory Committee (DAC) based on criteria such as clinical efficacy, safety and cost effectiveness. A new drug might not be introduced into the Formulary if its efficacy was on a par with that of the drugs in use in HA.

44. On the further enquiry raised by Dr PAN Pey-chyou as to whether an appeal mechanism was in place for the appellant to lodge complaints against the decision of DAC, Director (CS), HA replied in the positive.

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Categorisation of drugs in the Formulary

45. Mr Alan LEONG said that a number of new psychiatric drugs with fewer side effects were categorised as second-line drugs or Self-financed Items (SFI) under the Formulary. He urged HA to review the categorisation of drugs in the Formulary, with a view to increasing the use of new psychiatric drugs to ensure better clinical outcomes.

46. USFH said that all drugs included in the Formulary were proven to be cost-effective. In reviewing the cost-effectiveness of drugs for treatment of chronic diseases, HA would use the quality-adjusted life-years measure to ascertain the cost per quality-adjusted life-year gained.

47. Director (CS), HA supplemented that HA had progressively increased the use of new psychiatric drugs to improve treatment, as evidenced by the re-categorisation of some new psychiatric drugs, which were previously under the Special Drugs category, into the General Drugs category in the past two years. These drugs were available for general use as indicated by patients with relevant clinical conditions. However, psychiatric drugs with fewer side effects but were not more efficacious and outside specific therapeutic indications might be classified as drugs with marginal benefits over available alternatives.

Resources for purchasing drugs on HADF

48. Mr CHAN Hak-kan questioned whether the difference in the budget of the hospital clusters would constitute a variation on drug provision among different hospital clusters, thus depriving the patients of their rights to have equitable access to effective drug therapy.

49. Director (CS), HA responded that there was no cause for such concern, as drug policy and drug utilisation in all HA hospitals and clinics had been standardised with the introduction of the Formulary in 2005 to ensure that all patients would be given equitable access to cost effective drugs of proven efficacy and safety. HA would also take into consideration, inter alia, the resources required in purchasing drugs when allocating funding to the hospital clusters. Individual cluster/hospital would, according to their service scope and targeted patients, stock part of the some 1 300 drugs listed in the Formulary. Patients in similar clinical conditions would have access to similar drug therapy.

50. Ms Cyd HO asked whether, apart from adjustment for inflation based on pervious year's actual drug expenditure, HA had increased the funding allocated to individual cluster/hospital for purchasing drugs since 2005.

51. Director (CS), HA said that the level of subvention HA received from the Government was determined having regard to the resources required to maintain the existing level of services and to cope with new service demands set out in its annual plan. Where a proposed change to the Formulary (such as repositioning of SFI previously not covered by the safety net as items with safety net or

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Special Drugs) would involve significant resource implications, the relevant proposal by the Drug Utilisation Review Committee would be considered in the HA Annual Planning process. In 2008-2009, additional funding had been allocated to HA to meet the additional drug expenditure arising from the extended coverage of application of several drugs on the Formulary. The allocation of resources among hospital clusters for the procurement of drugs would also reflect the relevant changes made to the Formulary.

52. Dr PAN Pey-chyou said that some patients were no longer supplied with certain Special Drugs or SFI without safety net after being transferred from a specialist out-patient clinic (SOPC) to a general out-patient clinic (GOPC) for treatment, albeit that the clinical conditions of the patients remained unchanged. He asked whether this was due to the lack of resources of the pharmacies of GOPCs to stock these drugs.

53. Director (CS), HA said that GOPCs had been instructed to review and, where necessary, widen their scope of drugs so as to ensure that the transfer of a patient from SOPC to GOPC would not affect his/her drug therapy.

Safety net

54. Dr LEUNG Ka-lau said that middle-class families found it difficult to afford some extremely expensive SFI, such as cancer drug Imatinib (Glivec) and drugs for treatment of Mucopolysaccharidoses which would cost about $200,000 and at least $1 million per year respectively. He asked whether consideration would be given to put a cap, say, $100,000, on the expenses borne by each patient for purchasing SFI each year and the amount exceeding the cap should be covered by HA as part of its subsidised services.

55. Mr Alan LEONG also expressed concern about the safety net for patients with rare genetic lysosomal diseases. He cited a recent media report whereby the two children of a family were both Mucopolysaccharidoses patients.

56. USFH responded that for patients who had difficulties in meeting the drug expenses, financial support had all along been available to them via the Samaritan Fund, which currently covered eight SFI drugs. Needy patients could apply for assistance from the Fund to meet expenses on these drugs. Apart from the Fund, needy patients might seek fee waiver from HA. Under the fee waiver mechanism, a patient might be provided with one-off full or partial waiver for hospital fees and charges.

57. As regards the medical needs of patients with rare genetic lysosomal diseases, Chief Manager (Cluster Performance), HA (Chief Manager (CP), HA) said that HA currently sought to alleviate patients' discomfort and treat the complications arising from the disease through the collaboration of healthcare staff from various specialties, such as orthopaedics, otorhinolaryngology, ophthalmology and respiratory medicine, along with genetic counseling, as well as the provision of appropriate drugs, surgery and rehabilitation programme.

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These services were covered by the standard fees of HA. An Expert Panel on Rare Metabolic Diseases was also set up in 2007 to formulate the assessment criteria for the use of drugs on patients with rare genetic lysosomal diseases, including Mucopolysaccharidoses patients. However, there was no solid scientific data to prove the efficacy of drug therapies to improve the lung function of Mucopolysaccharidoses patients. Chief Manager (CP), HA added that in 2008, a pharmaceutical manufacturer had offered to provide drug therapies to Mucopolysaccharidoses patients for a period of one year for research purpose. To avoid giving the patients concerned a false expectation on the efficacy of the drug, the attending doctors had explained clearly that the efficacy of the drug had yet to be proved by substantial scientific research data.

58. Dr LEUNG Ka-lau expressed reservation about HA's remarks that drug therapies could not improve the lung function and the quality of life of patients with Mucopolysaccharidoses. In response, USFH said that he could provide Dr LEUNG with the relevant scientific research articles after the meeting.

Engagement with patient groups

59. Mr CHAN Hak-kan welcomed HA's initiative to establish a formal consultation mechanism with patient groups as set out in paragraph 15 of the Administration's paper. He asked about the views received from the patient groups on the Forumulary at the first consultation meeting held in May 2009. Ms Cyd HO raised similar question.

60. Director (CS), HA said that under the mechanism, annual consultation meeting would be held to inform patients of the latest developments of the Formulary, understand their major concerns, and solicit their views and suggestions on introduction of new drug items and review of existing drugs in the Formulary. After the meeting, patient groups would be given two months' time to submit their views to HA. HA would take their views into account when reviewing the list of drugs in the Formulary in the year ahead. At the request of the Chairman, Director (CS), HA undertook to provide to the Panel after completion of the current consultation exercise in end July 2009 a summary of views received on the Formulary.

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61. Mr Alan LEONG noted that DAC of HA would systematically appraise new drugs every three months. He asked whether HA would consider inviting patient groups to join DAC.

62. USFH said that when considering whether to introduce new drugs into the Formulary, DAC would take into account the scientific evidence on safety and efficacy, cost effectiveness, technology advances in treatment options and service scope in public hospitals. This would require professional knowledge on the part of doctors, clinical pharmacologists and pharmacists. Nonetheless, USFH assured members that HA would take into account views collected under the newly established consultation mechanism with patient groups when considering the introduction of new drug items and the review of existing drugs

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in the Formulary.

63. Whilst welcoming HA's initiative to establish a formal consultation mechanism with patient groups, Dr PAN Pey-chyou said that HA should also step up education for patients to enhance their understanding of the Formulary and the efficacy of the drugs. Director (CS), HA said that efforts had been and would continuously be made in this respect.

64. Mr WONG Kwok-hing opined that the Administration should set up an independent mechanism to review the Formulary and to receive complaints from patients concerning the use of drugs at HA hospitals/clinics. USFH said that more time should be given for HA to implement the newly established consultation mechanism with patient groups and to assess its effectiveness.

65. There being no other business, the meeting ended at 10:40 am.

Council Business Division 2
Legislative Council Secretariat
20 August 2009