立法會
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 2008-2009 Legislative Council (LegCo) session. It will be tabled at the Council meeting on 8 July 2009 in accordance with Rule 77(14) of the Rules of Procedure.

The Panel

2. The Panel was formed by resolution of the Council on 8 July 1998 and as amended on 20 December 2000, 9 October 2002, 11 July 2007 and 2 July 2008 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 Dr Hon Joseph LEE Kok-long and Dr Hon LEUNG Ka-lau elected as Chairman and Deputy Chairman respectively. The membership list of the Panel is in **Appendix II**.

Major work

Prevention and control of human swine influenza (HSI) in Hong Kong

5. Human cases of a new strain of swine influenza A (H1N1) virus infection were identified in April 2009 in Mexico, the United States (US) and Canada. According to the World Health Organization (WHO), the swine influenza

A(H1N1) viruses characterised in this outbreak had not been previously detected in pigs or humans. Having regard to the occurrence of human cases associated with an animal influenza virus, and the multiple community outbreaks which affected mostly healthy young adults, WHO raised the alert level for swine influenza pandemic to Phase 5 on 30 April 2009, signifying that a global pandemic was imminent. On 27 April 2009, the Administration gazetted "Swine influenza" as a statutorily notifiable disease with immediate effect under the Prevention and Control of Disease Ordinance (Cap. 599) and as a specified disease under the Prevention and Control of Disease Regulation (Cap. 599A).

6. The Panel held a total of five meetings, including one joint meeting with the Panel on Food Safety and Environmental Hygiene (the FSEH Panel) and three special meetings, with the Administration on the prevention and control of human swine influenza (HSI) in Hong Kong.

Nomenclature of swine influenza

7. Noting that "Influenza A (H1N1)" was used by WHO when referring to the new virus affecting humans, question was raised as to whether the Administration would change "Swine influenza" in Cap. 599 to "Influenza A (H1N1)".

8. The Administration advised that as "Influenza A (H1N1)" could be regarded as including all other influenza A (H1N1) infections, for example, seasonal influenza A (H1N1), other than the new human swine influenza virus, changing "Swine influenza" to "Influenza A (H1N1)" might confuse the local medical sector as to whether they were required to report all seasonal influenza A (H1N1) infections to the health authorities as well. Subject to further development on the nomenclature of this novel influenza virus, the name "Swine influenza" would continue to be used in Cap. 599.

Strategy and management of HSI

9. Members noted that the Administration's strategy then against pandemic influenza was containment for as long as it would take to delay community transmission, after which mitigation would take priority. Mitigation would apply when local transmission of HSI became significant and containment strategy was no longer appropriate or feasible, i.e. the occurrence of a confirmed local case that had no identifiable link, such as travel to an affected area in the previous seven days. Transition of management of HSI from containment to mitigation phase would depend on factors, such as epidemic progression (indicated by daily number of new cases and/or the effective reproduction number), disease severity (indicated by proportion of those infected with complications, requiring hospitalisation and case fatality), burden to medical services, resource capacity and effectiveness of

containment, and broader considerations in the community.

10. Members further noted that with new knowledge gained about the nature of this novel human swine virus, such as close contacts having around 22%-33% chance of getting infected and the absence of large scale environmental transmission as well as the availability of an effective prophylactic, plans for contact tracing and management of HSI in different settings, namely, inbound flight, hotel, home, workplace, elderly home, school and public places, in the containment phase had been devised by the Administration. For instance, in the event of an occurrence of a confirmed HSI case in a hotel setting during the late containment phase, the general guidance was that only guests and staff who stayed/served on the same floor/same service section on the same floor and other close contacts would be placed under medical surveillance and administered directly observed chemoprophylaxis.

11. Hon Vincent FANG questioned the necessity of imposing stringent health measures in Hong Kong, having regard to the facts that most affected places, such as the US, did not adopt any port health measures and that the HSI was relatively milder so far with limited mutability. Dr Hon LEUNG Ka-lau also questioned the need for Hong Kong to raise the response level to the highest level at "Emergency Response Level" under the Preparedness Plan for Pandemic Influenza in Hong Kong, upon the confirmation of an imported case of HSI infection in Hong Kong on 1 May 2009.

12. The Administration advised that although there appeared to be emerging evidence that this novel virus remained relatively mild so far with limited mutability and that Tamiflu remained an effective chemoprophylaxis against HSI so far, it should be pointed out that the outbreak of HSI in Mexico, which did not occur in its normal influenza season, had caused much disruption to the daily lives of its citizens and economy. Moreover, although the fatality rate of HSI was similar to that of seasonal influenza, with the exception of that in Mexico, the secondary attack rate of HSI was about 30% higher than that of seasonal influenza. Past records suggested that seasonal influenza (of different variety of virus strain and type from season to season) accounted for about 1 000 deaths in Hong Kong every year. However, even if the severity of HSI remained similar to seasonal influenza, it was as yet unclear if hospitalisation needs and deaths arising from it would substitute or add to that of seasonal influenza, particularly in the coming influenza peak season. Hence, although it was a matter of time before the first local HSI case occurred in Hong Kong, it was important for Hong Kong to continue to contain possible onward transmission by imported index cases during this late containment stage in order to delay community spread.

Use of Tamiflu

13. Concern was raised as to whether the Administration had adequate supply of antiviral drugs in time of outbreak in the community. The Administration advised that Tamiflu was presently prescribed to patients infected with HSI, as well as close and social contacts of the confirmed cases to prevent local transmission of the disease. However, if the management of HSI progressed into the mitigation phase upon the occurrence of the first confirmed local case that had no identifiable link, Tamiflu would only be prescribed to patients infected with HSI, as it was no longer feasible nor appropriate to treat close and social contacts where their risk of infection approximated that of the general public.

Suspension of classes

14. Some members, including Hon Andrew CHENG, were of the view that closure of schools for up to 14 days when the first local HSI case occurred should cover all secondary schools, in addition to all primary schools, kindergartens, nurseries and other pre-schools.

15. The Administration explained that limiting closure of schools to primary level and below was because according to WHO's assessment, young children were twice at risk at contracting HSI vis-a-vis young adults. Moreover, unlike young people in secondary schools, children aged 12 and below usually were less capable of adhering to good personal hygiene and keeping a distance from their classmates. The Administration, however, advised that it would require the secondary school with a confirmed case of HSI to suspend classes for up to 14 days. Suspending the classes of all secondary schools would not be ruled out if local transmission of HSI became sustained and significant.

Procurement of HSI vaccines

16. Some members, including Hon Audrey EU, Hon Vincent FANG, Hon Fred LI and Dr Hon LEUNG Ka-lau, questioned the Administration's plan to seek the approval from the Finance Committee (FC) of LegCo on 19 June 2009 on creating a new commitment of $700 million to meet an one-off non-recurrent HSI vaccines and injections expenditure for 2009-2010, when it was uncertain whether and how the virus would mutate as the epidemic evolved and that the vaccines being developed had yet to obtain approval from overseas drug authorities such as those of the US and the European Union (EU).

17. The Administration advised that as the some 30 vaccine manufacturers worldwide could only produce the HSI vaccines to meet the demand of some 5% of the world population, and as Hong Kong did not have the capability and capacity of manufacturing vaccines, taking an early decision was the only way that

Hong Kong could secure adequate supply of vaccines as international demand was becoming strong. Although regulatory approval of the HSI vaccines was still outstanding, the order to be placed by the Government, through tendering, would include safeguard clauses to require eventual approval of the vaccines from overseas drug authorities such as those of the US and/or EU. The Administration was presently gathering facts from several manufacturers on the quality, availability and price of the HSI vaccines.

18. On the eventual take-up rate of the HSI vaccines, the Administration advised that this would depend on various factors including the development of the pandemic in the next few months and public perception of the possible side effects of the vaccines. Demand for the vaccines would be greater if more people got infected and came down with serious illnesses. The cost involved in procuring and providing five million doses of HSI vaccines should be seen as the "insurance premium" to be paid by the community for safeguarding public health against HSI.

19. Some members were concerned about the possible side effects of the HSI vaccines and the implementation of the vaccinations. The Administration explained that after balancing the risks involved, it was more beneficial for the target group to receive HSI vaccines. The Administration would work out the detailed implementation plan for the vaccinations and brief the Panel in due course.

20. The proposal to create a new commitment of $700 million for procurement of HSI vaccines and the related injection was approved by FC on 19 June 2009.

Report on First Stage Public Consultation on Healthcare Reform

21. The Government published the Healthcare Reform Consultation Document "Your Health, Your Life" (the "Consultation Document") on 13 March 2008. The healthcare reform aimed to address the challenges to Hong Kong healthcare system brought about by a rapidly ageing population and rising medical costs, and to ensure the future sustainability of the system to deliver healthcare protection and quality services to the community. The first stage public consultation on health care conducted from March to June 2008 aimed at consulting the public on (a) the key principles and concepts of four service reform proposals, viz: enhancing primary healthcare service, developing an electronic database of patient records, strengthening public healthcare safety net, and promoting greater public-private healthcare partnership; and (b) the pros and cons of reforming the current healthcare financing arrangements through introducing six possible supplementary financing proposals, viz: social health insurance (mandatory contribution by workforce); out-of-pocket payments (increase user fees); medical

savings accounts (mandatory savings for future use); voluntary private health insurance; mandatory private health insurance; and personal healthcare reserve (mandatory savings and insurance).

22. Some members asked the Administration whether it would review its plan to implement mandatory medical savings or mandatory insurance as supplementary financing, in the light of the recent global financial turmoil.

23. The Administration advised that it 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.

24. On the suggestion of charging user fees for public healthcare services based on users' income, the Administration pointed out 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 difficulty to pay the medical bill if they had heavy and/or long-term need of healthcare.

25. Concern was raised as to how the Administration would reconcile the divergent views on the six supplementary financing proposals put forth in the Consultation Document. The Administration 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.

26. On the question of when stage-two public consultation on healthcare reform would be launched, the Administration advised that it 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.

<u>Regulation and control of pharmaceutical products</u>

27. In the light of the recent incidents concerning pharmaceutical products in Hong Kong, such as fungal contaminated Allopurinol, the Secretary for Food and Health announced on 19 March 2009 the setting up of a Review Committee to conduct a comprehensive review on all the relevant issues including safety and quality assurance of drugs, standard and practices of the pharmaceutical industry, and whether there is a need for legislative amendments. To support the work of

the Review Committee, the Director of Health has set up a Task Force to comprehensively review the existing control of the drug supply chain, including manufacturers, importers, wholesalers and retailers, as well as the control of drugs. An Expert Group on Microbiological Hazards on Drug Manufacturing will also make proposals to the Task Force. HA would also implement seven initiatives, such as requiring manufacturers to introduce microbiology testing as a prerequisite to the procurement for high risk drug items and for the provision of batch release reports on delivery of drug products, to strengthen its procurement of drugs.

28. Members considered that the main reason for the recent drug incidents was the inadequate manpower of DH to perform inspection and surveillance on the drug supply chain. The Administration advised that as an immediate measure the Department of Health would recruit 10 additional pharmacists to strengthen inspection to manufacturers, wholesalers and retailers of drugs and the sampling of drugs for analysis. More pharmacists might be recruited upon completion of work by the Review Committee in six to nine months' time.

29. Hon Andrew CHENG opined that another reason was because the General Manufacturing Practices (GMP) used in Hong Kong was less stringent than the GMP used in countries such as Singapore, Australia and US. The Administration clarified that the fact that GMP in countries such as US, EU and Australia was recognised to be of a standard higher than GMP in Hong Kong should not be taken to mean that GMP in Hong Kong was substandard, as GMP used in Hong Kong followed exactly the GMP guidelines promulgated by WHO. The reason why the GMP in US, EU and Australia was recognised to be of a higher standard was because manufacturers in these countries also produced new/patent drugs which required more detailed and rigorous quality requirements, whereas local manufacturers only produced off-patent generic drugs. Nevertheless, to enhance safety and quality assurance of drugs, plan was in hand to make certain GMP aspects governing high risk manufacturing process in Hong Kong more comprehensive. For instance, one of the major works of the Review Committee would involve expanding the scope of GMP to include microbiological testing for high risk drug items.

30. On the suggestion of raising the penalty to ensure GMP compliance, the Administration advised that a demerit point system capable of proportionate penalty ranging from for example written warnings, announcement of serious noncompliance cases, suspension or termination of licences would be considered by the Review Committee.

31. The Panel noted that the Administration would implement any enhancement measures where practicable prior to completion of work by the Review Committee. The Panel would continue to monitor the progress of the review of the existing regulatory regime on pharmaceutical products.

Development of a territory-wide electronic health record sharing system

32. The development of a territory-wide healthcare record (eHR) sharing system for healthcare professionals in both the public and private sectors to enter, store and retrieve patients' records, subject to authorisation by the patients, was set out in the Consultation Document. The territory-wide eHR sharing system can enhance continuity of care as well as better integration of different healthcare services for the benefits of individual patients. It can also facilitate the implementation of various healthcare reforms, including enhancing primary care in both the public and private sectors, as well as promoting public-private partnership in the provision of healthcare services.

33. Some members considered that the about $1,124 million capital costs for the development of the eHR system for the 10-year planning horizon from 2009-2010 to 2018-2019 was on the high side.

34. The Administration pointed out 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 Clinical Management System (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, Canada and the 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 would be of a much smaller scale, making the total investment well below those overseas.

35. The Administration further pointed out 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.

36. Hon 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.

37. The Administration advised that the Privacy Commissioner for Personal Data 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. Ample measures in terms of technical design and operation would be taken to safeguard the data privacy and security of the eHR sharing system, and the system would be leveraged upon HA's expertise and know-how in the development of its CMS since 1995 for storing and retrieving patients' medical records.

38. The Administration further advised that legislative work would be needed and the proposed eHR Office would proceed with studies and preparatory work in this regard. 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. Legal sanctions for unauthorized access and disclosure would also be considered as part of the legal framework to be formulated.

39. Members were concerned about the success of the project if the participation of the private doctors in eHR sharing system was not high. On the suggestion of providing subsidies to private doctors to incentivise them in joining the eHR sharing system, the Administration did not see the justification nor need to do so. Apart from providing capital investment for the development of eHR sharing system, the Government had also planned to fund individual eHR sharing partnership. The principle of Government investment was that no subsidies would be provided to cover the day-to-day operation of private healthcare providers. Private sector partners should be responsible for their own hardware and recurrent costs, as well as the costs incurred by the development of any additional or special components of their systems. The Administration, however, pointed out that the cost to be borne by the private sector participating in eHR sharing would not be much. There were now private IT firms providing eHR sharing services. For a private practitioner, the cost for setting up such a system in a private clinic was around $20,000, and the monthly service fees including the network fee ranged from $800 to $1,500. The Administration further 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.

40. The Administration was requested to provide its strategy on encouraging private doctors to join the eHR sharing system and to include frontline doctors from the public sector on the Steering Committee, before submitting its funding proposal to FC for developing the project.

Allocation of resources among hospital clusters by HA

41. Members noted that under the new "Pay for Performance" system, resources would be allocated on the basis of the output and workload of hospitals. This was achieved through the adoption of a casemix approach, which referred to a way of classifying the acute inpatients 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.

42. On the question of how the new "Pay for Performance" system could help to address the present under-provision of funding to certain clusters, such as the New Territories West Cluster, the Administration advised 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, funding growth in targeted activities; funding for quality improvement programmes; and funding for technology advancement, service improvement and workforce supply.

43. Concern was raised that some general hospitals would turn into specialist hospitals as a result of the implementation of the new "Pay for Performance" system. The Administration advised that there was no cause for such concern as the roles and functions of each hospital/hospital cluster were co-ordinated centrally by the 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.

44. On whether the new "Pay for Performance" system would replace the existing hospital clustering arrangements and the timetable for expanding the United Christian Hospital to better meet the needs of people living in the Kowloon East region, the Administration advised that the new system was only a new internal resource allocation system for funding hospital clusters and had no bearing on the hospital clustering arrangements. The Administration was forging ahead with the planning work of the United Christian Hospital.

45. Whilst supporting the casemix approach, Dr Hon PAN Pey-chyou was of the view 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 manpower planning. The Administration advised 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.

Other matters discussed

46. Other subject matters discussed by the Panel included the new campaign to promote organ donation, advance directives in relation to medical treatment, operation of mortuaries in public hospitals, handling of requests from the public for urgent medical assistance by public hospitals, phase two redevelopment of Caritas Medical Centre, report on findings of technical feasibility study on smoking room and policy on use of drugs in life threatening emergency situations.

47. The Panel was also consulted on the Administration's proposals to inject $1 billion to the Samaritan Fund, relocate Siu Lam Hospital to Block B of Castle Peak Hospital and develop phase one of the North Lantau Hospital project.

48. From October 2008 to June 2009, the Panel held a total of 16 meetings, including one joint meeting with the FSEH Panel on the prevention and control of HSI in Hong Kong.

Council Business Division 2
Legislative Council Secretariat
3 July 2009

Appendix I

Legislative Council

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 2008 - 2009 session

Chairman	Dr Hon Joseph LEE Kok-long, SBS, JP
Deputy Chairman	Dr Hon LEUNG Ka-lau
Members	Hon Albert HO Chun-yan Hon Fred LI Wah-ming, SBS, 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 (Total : 13 Members)
Clerk	Miss Mary SO
Legal adviser	Mr Stephen LAM
Date	1 July 2009