立法會
Legislative Council

LC Paper No. CB(2)1224/09-10
Ref : CB2/PL/HS (These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 8 March 2010, at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, SBS, JP (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon Fred LI Wah-ming, SBS, JP Hon CHEUNG Man-kwong Hon Andrew CHENG Kar-foo Hon Audrey EU Yuet-mee, SC, JP Hon Cyd HO Sau-lan Hon CHAN Hak-kan Hon CHAN Kin-por, JP Hon CHEUNG Kwok-che Dr Hon PAN Pey-chyou
Member absent	:	Hon IP Kwok-him, GBS, JP
Public Officers attending	:	Item IV Dr York CHOW, GBS, JP Secretary for Food and Health Mr Thomas CHAN, JP Deputy Secretary for Food and Health (Health) 2 Mr Bruno LUK Principal Assistant Secretary for Food and Health (Health) 3 Dr W L CHEUNG Director (Cluster Services) Hospital Authority

Dr FUNG Hong
Cluster Chief Executive, New Territories East Cluster
Hospital Authority

Dr Jenny LAM
Deputizing Chief Manager (Service Transformation)
Hospital Authority

Item V

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

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

Dr Heston KWONG
Assistant Director of Health (Special Health Services)

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

Staff in attendance : Mr Stephen LAM
Assistant Legal Adviser 4

Ms Maisie LAM
Senior Council Secretary (2) 6

Ms Sandy HAU
Legislative Assistant (2) 5

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I. Confirmation of minutes
(LC Paper No. CB(2)1014/09-10)

The minutes of the meeting held on 8 February 2010 were confirmed.

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

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

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III. Discussion items for the next meeting
(LC Paper Nos. CB(2)1015/09-10(01) and (02))

3. Members agreed to discuss the following items proposed by the Administration at the next regular meeting scheduled for 12 April 2010 at 8:30 am -

(a) Second phase smoking ban at public transport interchange;

(b) Final Report on Doctor Work Reform; and

(c) Enhancing Primary Care - Establishment of Primary Care Office.

4. Mr CHAN Hak-kan proposed to discuss an interim review on the implementation of the Elderly Healthcare Voucher Pilot Scheme at a future meeting, having regard to the media reports about improper voucher reimbursement claims by some healthcare service providers enrolled in the Scheme.

5. Mr CHEUNG Kwok-che proposed to discuss the issue of shortage of nurses within the current legislative session.

6. The Chairman suggested and members agreed to include the two items mentioned in paragraphs 4 and 5 above in the list of outstanding items for discussion by the Panel.

IV. Healthcare Service Reform - Shared Care Programme
(LC Paper Nos. CB(2)1015/09-10(03) and CB(2)1059/09-10(01))

7. Secretary for Food and Health ("SFH") briefed members on the Shared Care Programme (the Programme) to be introduced by the Government through the Hospital Authority ("HA"), details of which were set out in the Administration's paper (LC Paper No. CB(2)1015/09-10(03)) tabled at the meeting. Deputy Secretary for Food and Health (Health) 2 then conducted a power point presentation on the details of the pilot Programme as set out in the power point materials (LC Paper No. CB(2)1059/09-10(01)) tabled at the meeting.

8. Ms Audrey EU asked the Administration why its paper on the pilot Programme was not provided to members before the meeting. SFH explained that the Administration wished to first brief the Panel on the pilot Programme before holding a press conference later in the day to launch the Programme.

Scope and coverage of the Programme

9. Mr CHEUNG Man-kwong asked whether consideration would be given to extending the Programme to other hospital clusters and other chronic disease patients in stable conditions by phases throughout the three-year pilot period. Dr LEUNG Ka-lau was also of the view that the pilot period of the Programme could be shortened from three years to one year. Dr LEUNG pointed out that the

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areas that needed to be improved to the three-year Elderly Healthcare Voucher Pilot Scheme became apparent within six months to one year after the implementation of the pilot Scheme.

10. SFH responded that HA would engage an independent assessment body to continuously evaluate the arrangements and effectiveness of the Programme during the pilot period. The service capacity of the Programme was about 10 000 to 20 000 patients, including about 1 000 patients in the initial stage. Although the Programme would initially primarily target diabetes mellitus ("DM") and hypertension ("HT") patients who were currently taken care of by the public specialist out-patient clinics ("SOPCs") or were formerly under the care of SOPCs but had been transferred to the public general out-patient clinics ("GOPCs") in Tai Po and Sha Tin, the Administration would consider extending the Programme to other hospital clusters and other chronic disease patients in stable conditions during the pilot period having regard to the evaluation results and experience from the Programme. The Administration would not rule out the possibility of extending the Programme to another hospital cluster within the first year.

11. SFH further said that although there were at present about 500 000 chronic disease patients under the care of the public healthcare system, not all of them were eligible for the Programme, i.e. they must have started receiving care at public SOPCs at least two years ago and have been assessed to be clinically stable and could continue to receive care in the primary care settings, and not all eligible patients would choose to participate in the Programme. As regards the Elderly Healthcare Voucher Pilot Scheme which was launched on 1 January 2009, SFH said that the Administration would conduct an interim review of the pilot Scheme in mid-2010. Decision would be made at the end of the year on whether, and if so, how the pilot Scheme should be taken forward.

12. Mr CHAN Kin-por urged the Administration to expedite the pace of extending the Programme, so as to allow chronic disease patients currently taken care of by other hospital clusters to participate in the Programme. Mr CHEUNG Kwok-che expressed a similar view.

13. Dr LEUNG Ka-lau asked the Administration -

(a) whether it would increase the some 1 000 quota for the Programme in the initial stage, if more than 1 000 eligible DM and HT patients who were currently under the care of public SOPCs and GOPCs in Tai Po and Sha Tin expressed interest in participating in the Programme; and

(b) whether it would report back to the Panel the outcome of the interim review of the Programme one year after implementation.

SFH and Director (Cluster Services), HA responded in the positive to Dr LEUNG's questions.

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14. Ms Audrey EU noted that apart from the Programme, the Government had also launched in phases, through HA, several pilot projects to enhance support for chronic disease patients in the primary care settings. Ms EU asked in what aspects were the Programme different from other pilot projects to enhance support for chronic disease patients in the primary care settings, and whether, and if so, how the experience from these other pilot projects had contributed to the formulation of the Programme. SFH agreed to provide a response in writing after the meeting.

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Subsidy for patients

15. Dr PAN Pey-chyou noted that participating doctors had to provide patients with a minimum of four consultations (inclusive of drugs) per year (normally four to six consultations were required) at an interval of not more than four months between each consultation to ensure the continuity of care provided to patients. Dr PAN queried whether providing $1,200 for each patient per year for subsidising consultation/case management provided by private doctors (inclusive of drugs) was adequate.

16. SFH responded that the subsidy was intended to be a partial one. On top of the subsidy, participating patients had to pay out-of-pocket the fees listed by private doctors for providing services for treating DM and HT, albeit the amount should be lower than that if they were to receive services for treating DM and HT from private doctors without participating in the Programme.

17. Mr CHAN Hak-kan expressed concern that the co-payment by participating patients would be high, as private doctors generally charged $400 to $500 per consultation (inclusive of drugs) for treating DM and the DM patients normally required four to six consultations per year.

18. SFH responded that the objective of the Programme was to enhance support for chronic disease patients in primary care settings through shared care between the public and private sectors. Currently, chronic disease patients who received treatment at public SOPCs and were clinically stable could be referred to neighbouring public GOPCs to follow up on their conditions. The Programme would provide additional choices of private services for these patients and allow patients to choose neighbouring private doctors of their choice to follow up on their conditions, receive partial subsidy for receiving comprehensive management, and establish long-term patient-doctor relationships in order to achieve the objective of continuous and holistic care. The Programme would ensure that the private service providers would follow the appropriate chronic disease care model and clinical protocols, as participating doctors were required to provide patients with comprehensive and continuous care based on the conceptual model and clinical protocols developed by the Working Group on Primary Care. It should be pointed out that some chronic disease patients currently under the care of HA also sought services from private doctors at the same time. Director (Cluster Services) HA supplemented that participation in the Programme was voluntary. Patients should

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weigh the benefits of participating in the Programme, such as continuous care with the same doctor and convenience, and whether they could afford the co-payment.

19. Mr CHEUNG Kwok-che asked -

(a) what was the amount which participating patients were expected to co-pay per consultation; and

(b) what measures would be taken if participating patients were dissatisfied with the services provided by participating doctors.

20. SFH responded as follows -

(a) private doctors who indicated interest in participating in the Programme had yet to provide information on the fees that they would charge patients;

(b) participating patients could choose to receive services and drugs which were not covered under the Programme or were not related to the management of DM and HT. However, such services and drugs would not be subsidised and patients had to pay out-of-pocket in full the fees charged by private doctors; and

(c) participating patients with good cause might request to switch private doctors. Arrangements would be made by HA on a case-by-case basis.

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21. The Chairman requested the Administration to provide a paper setting out the listed fees to be charged by the participating doctors when the information became available.

22. In response to Dr LEUNG Ka-lau's enquiry on the charging of fees of participating doctors, SFH said that they were required to (i) publicise upfront the fees that they expected to charge each patient per year on top of the subsidy amount; (ii) notify HA in advance when they intended to adjust their fees; and (iii) document in an electronic system the fees charged for any service used for treating DM and HT. The Food and Health Bureau and the New Territories East Cluster of HA had consulted private doctors practising in Tai Po and Sha Tin as well as relevant doctor groups on the Programme. The current arrangements of the Programme had taken into account their views.

23. Mr CHAN Kin-por asked whether consideration would be given to -

(a) requiring participating doctors to publicise in their clinics the fees that they expected to charge each participating patient per year on top of the subsidy amount; and

(b) providing separate subsidy for DM and HT patients.

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24. Director (Cluster Services) HA responded as follows -

(a) information on the fees that participating doctors were expected to charge each participating patient per year on top of the subsidy amount would be provided in the invitation letters to eligible patients; and

(b) there was no need to provide separate subsidy for DM and HT patients as both groups of patients only required two to four types of drugs. HA was open-minded on providing separate subsidy for patients suffering from other chronic disease, where appropriate, in future.

25. Ms Audrey EU asked whether HA would provide drugs for participating doctors, so as to reduce the amount of co-payment by patients.

26. Director (Cluster Services), HA responded that a drug list, based on its Drug Formulary, would be provided by HA to participating doctors for reference. As the drugs on the list were generic (non-patent) drugs, it should not cost the private doctors excessively than if the drugs were purchased by HA. Director (Cluster Services), HA further said that experience from the pilot project to purchase primary care services from the private sector in Tin Shui Wai ("TSW"), launched in June 2008, revealed that for HA to deliver drugs to the clinics of participating doctors, the model would also incur significant administrative costs.

27. Mr Andrew CHENG urged the Administration to expeditiously come up with a way forward on healthcare financing, instead of making some better-off patients shoulder some of the medical costs through a shared care model. To prevent private doctors participating in the Programme from over-charging patients, Mr CHENG suggested that HA should fix the fees which doctors could charge patients for prescribing drugs on the drug list. Mr CHENG surmised that the main reason why only six private doctors participated in the TSW pilot project was because they could not charge patients for the drugs which were provided by HA free of charge.

28. Director (Cluster Services), HA responded that participating doctors were required to publicise upfront the fees that they expected to charge each patient per year on top of the subsidy amount. Director (Cluster Services), HA further said that it was not appropriate to compare the Programme with the TSW pilot project, as the target patients and the objective of the two projects were different. The TSW pilot project was to allow chronic disease patients in stable conditions and in need of long-term follow-up treatment at public GOPCs to voluntarily participate in the pilot project and receive treatment from participating private doctors practising in the district. HA would pay fees to participating doctors in accordance with the service contract while participating patients were only required to pay the same fee as charged by GOPCs. The pilot project aimed to strengthen the public general out-patient services in the district in order to address the increasing service demand

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and enhance the medical care rendered to chronic disease patients.

29. Mr Andrew CHENG further said that the Programme might deter some private doctors from participating, as many private doctors mainly used paper-based patient records. Even if private doctors used computer systems to store patient records, such systems were often stand-alone systems and not designed for electronic sharing. In the light of this, Mr CHENG requested the Administration to provide information in writing after the meeting the assistance and support it would provide to private doctors interested in participating in the Programme on the setting up of an electronic system in their clinics to share the patients' health records with HA's Clinical Management System.

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30. Ms Cyd HO asked whether providing a subsidy of $1,200 to each public patient per year to use services provided by the private sector would help HA save costs.

31. SFH responded that the objective of the Programme was not to save costs. Nor would the Programme help to save costs, as demand for services at public clinics would remain high despite the fact that some chronic disease patients would choose to participate in the Programme. SFH further said that the promotion of public-private partnership in healthcare services did not mean that funding to HA would be reduced. The Administration was committed to increasing progressively the health budget from 15% to 17% of the Government's recurrent expenditure by 2012.

32. Whilst noting that the Programme would not result in cost savings by HA, Ms Cyd HO queried whether the cost of transferring some chronic disease patients currently under the care of public clinics to the private sector by providing each of them with $1,400 (including an $200 incentive) was lower than the cost of providing care to them in the public clinics. In the light of this, Ms HO requested the Administration to provide the cost per consultation at public clinics. The Chairman also requested the Administration to provide the estimated average waiting time of patients at public SOPCs and GOPCs following the implementation of the Programme.

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33. Dr PAN Pey-chyou noted that to encourage patients to participate more actively and continuously in the management of chronic diseases, the Administration would provide an incentive of up to $200 per year for patients who could meet the preset health outcome indicators and comply with the care requirements prescribed by their doctors (such as regular follow-ups and drug compliance). Subject to confirmation of achieving the indicators every 12 months after the patients' participation in the Programme, the incentive would be deposited in the electronic healthcare voucher accounts of eligible patients for their use in future consultations. Dr PAN remarked that it was very difficult to preset health outcome indicators for chronic diseases, save with the exception of DM.

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Support services for patients

34. Dr PAN Pey-chyou asked whether participating doctors could refer participating DM patients to HA for support services such as dietary and chiropodic services.

35. SFH responded that apart from consultation/case management and drugs provided by the private doctors that they had selected, participating patients could also receive laboratory services and health risk assessments provided by HA as specified in the clinical protocols and through private doctors' referral. Private doctors could, on the basis of clinical diagnosis, refer patients to HA for additional laboratory services related to treatment of DM and HT. HA would not charge patients additional fees for such services.

36. Director (Cluster Services), HA supplemented that HA would conduct a comprehensive health risk assessment on each eligible patient elected to join the Programme at the outset and every year thereafter. Results of the assessment would also be provided to the doctor whom the patient had selected, so as to better enable the doctor to provide appropriate care to the patient. HA would continue to monitor the conditions of patients, provide adequate support for private doctors and patients, and allow patients with deteriorating conditions to go back to SOPCs for timely management. Moreover, starting from March 2010, HA would launch a pilot Patient Empowerment Programme in collaboration with non-governmental organisations in the Hong Kong East and New Territories East Clusters to teach chronic patients to improve their lifestyle, so as to raise their awareness of the diseases and enhance their self-care ability. Under the programme, a multi-disciplinary team comprising allied health professionals from HA would develop appropriate teaching materials and aids for various types of common chronic diseases and provide training for the frontline staff of the participating organisations. The programme would target at DM and HT patients in the initial stage and would be extended to cover other chronic disease patients later.

Service monitoring

37. Mr CHAN Hak-kan asked about the measures to monitor the services provided by participating doctors. Ms Cyd HO raised a similar question.

38. Director (Cluster Services), HA responded that to ensure that participating patients were receiving the appropriate care and were not over-charged, participating doctors were required to enter patients' clinical information through an electronic system and share the patients' health records with HA's Clinical Management System. Besides, doctors were required to enter the services which were related to the management of DM and HT and their fees, including prescription of drugs on and outside the HA Drug Formulary, and laboratory services. HA would also monitor the seeking of consultations from participating private doctors through the electronic system. If necessary, HA would contact the patient concerned and his/her attending private doctor to understand the situation and take appropriate follow-up actions,

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including arranging that patient to be transferred back to public clinics or to another participating private doctor for further care.

Other issues

39. Dr PAN Pey-chyou made the following points -

(a) the Programme might not appeal to patients who had all along been taken of by public SOPCs, as private doctors participating in the Programme were not specialists;

(b) public doctors might not be willing to encourage eligible patients to participate in the Programme, having regard to the fact that caseload was one of the criteria for allocation of resources to hospitals by HA; and

(c) frontline doctors working at public clinics could not afford to spare their already short consultation time to explain to their patients of the Programme.

40. SFH and Director (Cluster Services), HA responded as follows -

(a) some private doctors participating in the Programme were specialists in family medicine. HA would organise training and sharing sessions to enhance private doctors' capability in providing comprehensive and continuous care for chronic disease patients;

(b) there was no cause for concern that public doctors might not be willing to encourage eligible patients to participate in the Programme, having regard to the high demand for services at public clinics. On the contrary, the implementation of the Programme should result in shorter waiting time for medical services at public clinics and longer consultation time for patients; and

(c) HA would set up help desks at the Alice Ho Miu Ling Nethersole Hospital in Tai Po and the Prince of Wales Hospital in Sha Tin as well as telephone hotline to answer enquiries from members of the public, patients and private doctors on operation details of the Programme and to provide support to those who had participated in the Programme. Frontline doctors would only be required to assess whether the patients were clinically stable and could continue to receive care in the primary care settings.

Conclusion

41. In closing, the Chairman requested the Administration to provide responses in writing to questions raised by members at the meeting and to revert to the Panel on the progress of the Programme one year after implementation. SFH agreed.

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V. Human Organ Transplant (Appeal) Regulation
(LC Paper Nos. CB(2)1015/09-10(04) & (05))

42. Under Secretary for Food and Health ("USFH") briefed members on the Human Organ Transplant (Appeal) Regulation proposed to be made by SFH under the Human Organ Transplant Ordinance (Cap. 465) ("the Ordinance") to provide for rules and procedures for appealing against a decision made by the Director of Health ("the Director") in respect of an application for exemption of organ products from the Ordinance, details of which were set out in the Administration's paper (LC Paper No. CB(2)1015/09-10(04)).

43. Mr Albert HO asked why certain products made from human tissues could be exempted from the prohibition against commercial dealings under the Ordinance.

44. USFH responded that in recent years, advances in medical technology had resulted in the commercial production of certain products made from human tissues for transplant purposes, such as skin substitutes and derived bone products. These products fell within the definition of "organ" in the Ordinance, and the commercial dealings of which were prohibited under the Ordinance enacted in 1995. However, these products were gradually becoming more widely used by medical professions in foreign jurisdictions for treatment. To provide the Hong Kong medical profession with the opportunity to use these products for treatment, the Legislative Council ("LegCo") passed the Human Organ Transplant (Amendment) Ordinance 2004 ("the Amendment Ordinance") on 9 July 2004 to revise the definition of "organ", provide for a mechanism for exempting these products from the Ordinance, and put in place an associated appeal mechanism to handle appeals against decisions on exemptions.

45. Mr Albert HO asked whether it was lawful to pay the donor for supplying the tissues from his/her body for transplant purpose. USFH replied in the negative. Under the exemption mechanism, the Director might exempt, on a case-by-case basis, an organ product from the application of the Ordinance, including the prohibition against commercial dealings, provided that the Director was satisfied (i) that using the product for transplant purposes was safe and had no adverse impact on public health; (ii) either that the donor of the tissues concerned had given his/her consent to the removal of the tissues for the purpose of producing the product without coercion or the offer of inducement, or that the tissues were removed for the therapy of the donor; (iii) that no payment had been made, or was intended to be made to that donor for his/her supplying the tissues from his/her body; (iv) that all applicable laws of the place where the tissues were obtained or processed had been complied with in obtaining and processing the tissues; and (v) that the circumstances and manner in which the tissues were obtained and processed were not affected by any matter that the Director might consider to be objectionable.

46. Dr LEUNG Ka-lau asked -

(a) why the exemption mechanism had not come into operation, despite the fact that the Amendment Ordinance was enacted on 22 July 2004; and

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(b) whether applications for exemption of organ products from the Ordinance were patient-based.

47. USFH responded as follows -

(a) the Administration needed to first appoint a date, i.e. 15 February 2007, on which the provisions of the Amendment Ordinance to revise the function, constitution of the Human Organ Transplant Board and protect the Board members from personal liability should come into operation. The remaining provisions of the Amendment Ordinance, including those dealing with the application and granting of exemption and the establishment of an Appeal Board to handle appeals against decisions on exemption, would come into operation on a date to be appointed by SFH by gazettal of a commencement notice after the subsidiary legislation to provide for the rules and procedures for appeal was approved by way of negative vetting within the current legislative session; and

(b) suppliers of products derived from human tissues intended for transplant purpose were the potential applicants for exemption of organ products from the Ordinance. Hence, there should be no need for individual patient or his/her attending doctor to apply for exemption under the Ordinance.

48. Ms Cyd HO said that due to the time limit for LegCo Members to scrutinise the proposed rules and procedures for appeal under the negative vetting procedure, the Administration should fully consult all stakeholders before tabling the subsidiary legislation at the Council. USFH responded that it was the Administration's plan to do so. For instance, the Administration would seek the views of LegCo Members, particularly those who were members of the Bills Committee on Human Organ Transplant (Amendment) Bill 2001, and political parties/groups. USFH further said that the proposed rules and procedures for appeal were modeled on similar provisions in the local legislation.

49. There being no other business, the meeting ended at 10:25 am.

Council Business Division 2
Legislative Council Secretariat
8 April 2010