# 立法會
# *Legislative Council*

Ref : CB2/PL/HS

LC Paper No. CB(2)979/10-11
(These minutes have been seen by the Administration)

**Panel on Health Services**

**Minutes of meeting**
**held on Monday, 10 January 2010, at 8:30 am**
**in Conference Room A of the Legislative Council Building**

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| **Members present** | : | Dr Hon LEUNG Ka-lau (Chairman)<br>Dr Hon Joseph LEE Kok-long, SBS, JP (Deputy Chairman)<br>Hon Albert HO Chun-yan<br>Ir Dr Hon Raymond HO Chung-tai, SBS, S.B.St.J., JP<br>Hon Fred LI Wah-ming, SBS, JP<br>Hon CHEUNG Man-kwong<br>Hon Andrew CHENG Kar-foo<br>Hon LI Fung-ying, SBS, JP<br>Hon Audrey EU Yuet-mee, SC, JP<br>Hon CHAN Hak-kan<br>Hon CHAN Kin-por, JP<br>Hon CHEUNG Kwok-che<br>Hon IP Kwok-him, GBS, JP<br>Dr Hon PAN Pey-chyou<br>Hon Albert CHAN Wai-yip |
| **Members attending** | : | Hon WONG Kwok-hing, MH<br>Hon LEE Wing-tat |
| **Members absent** | : | Hon Cyd HO Sau-lan<br>Hon Alan LEONG Kah-kit, SC |
| **Public Officers attending** | : | Items IV and V<br><br>Dr York CHOW Yat-ngok, GBS, JP<br>Secretary for Food and Health |

Mr Thomas CHAN, JP
Deputy Secretary for Food & Health (Health) 2

Mr Chris SUN
Principal Assistant Secretary for Food and Health (Health) 3

Item IV only

Dr Joseph CHAN, JP
Consultant i/c Dental Service
Department of Health

Item V only

Dr Amy CHIU, JP
Head, Primary Care Office
Department of Health

Dr Daisy DAI
Chief Manager (Primary and Community Services)
Hospital Authority

Item VI

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

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

Mr CHOW Wing-hang
Principal Assistant Secretary for Security (D)

Dr Gloria TAM, JP
Deputy Director of Health

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

Mrs KWAN CHAN Suet-mui
Assistant Director (Information Systems)
Immigration Department

Dr W L CHEUNG
Director (Cluster Services)
Hospital Authority

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| | | Dr K H LEE<br>Chief Manager (Financial Planning)<br>Hospital Authority |
| **Clerk in attendance** | : | Ms Elyssa WONG<br>Chief Council Secretary (2)5 |
| **Staff in attendance** | : | Ms Maisie LAM<br>Senior Council Secretary (2)6<br><br>Ms Sandy HAU<br>Legislative Assistant (2)5 |

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## I. Confirmation of minutes
(LC Paper No. CB(2)728/10-11)

The minutes of the meeting held on 13 December 2010 were confirmed.

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

2. No information paper was issued since the last meeting.

## III. Items for discussion at the next meeting
(LC Paper Nos. CB(2)729/10-11(01) and (02))

3. Members agreed to discuss the item "Drug Formulary of the Hospital Authority" proposed by the Administration at the next regular meeting scheduled for 14 February 2011 at 8:30 am. Members noted that the subjects of "Oral chemotherapeutic drugs for cancer patients in public hospitals" and "Iron chelating therapy for Thalassaemia patients in public hospitals" would be discussed in the context of the item on drug formulary.

4. In response to the Chairman's enquiry about when the Administration would revert to the Panel on the outcome of its interim review of the Elderly Healthcare Voucher Pilot Scheme, Secretary for Food and Health ("SFH") replied that the Administration planned to revert to the Panel on the subject towards the end of the first quarter of 2011.

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**IV. Pilot project on outreach primary dental care services for elderly in residential care homes and day care centres**
(LC Paper Nos. CB(2)729/10-11(03) and CB(2)761/10-11(01))

5. SFH briefed members on a pilot project to provide outreach primary dental care and oral health care services to elderly people in residential care homes ("RCHEs") and Day Care Centres for the Elderly ("DEs") ("the Pilot Project"), details of which were set out in the Administration's paper (LC Paper No. CB(2)729/10-11(03)).

Scope of the Pilot Project

6. Mr Fred LI expressed support for the Pilot Project. He suggested that further improvement could be made by also providing subsidy to elderly people who were neither institutionalized older persons ("IOPs"), DE service users nor Comprehensive Social Security Assistance ("CSSA") recipients and were unable to afford the dental expenses due to lack of means. Dr PAN Pey-chyou was of the view that in the long run, all elderly people should be eligible for free primary dental care services. Whilst welcoming the introduction of the Pilot Project, Mr WONG Kwok-hing and Ms Audrey EU asked whether consideration could be given to extending the Pilot Project to other groups of elderly people before completion of the three-year pilot period.

7. SFH responded that the Administration would consider whether the Pilot Project should be extended to other groups of elderly people by phases having regard to the experience from the Pilot Project, such as whether access to primary dental care could lead to an improvement in the health and quality of life of the elderly, as well as the availability of financial and manpower resources. An interim review of the Pilot Project would be conducted after the implementation of the Pilot Project for two years to decide whether, and if so, how the Pilot Project should be taken forward.

8. SFH further said that elderly people aged 70 or above could use the healthcare vouchers provided under the Elderly Health Care Voucher Pilot Scheme to seek dental services in the private sector. It should however be noted that the Pilot Scheme was not meant to provide full subsidies to elderly people for their use of private primary care services, including dental services, as individuals should be responsible for their own health. Mr WONG Kwok-hing urged the Administration to increase the total value of the five Elderly Health Care Vouchers from $250 to $1,000 per annum in the next financial year.

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9. Dr PAN Pey-chyou sought clarification as to whether the Pilot Project covered IOPs residing in private RCHEs licensed by the Social Welfare Department. SFH replied in the affirmative although participation by individual RCHEs in the Pilot Project would be voluntary. Moreover, the RCHEs concerned had to ensure that it had enough space to temporarily accommodate the outreach dental equipment for the provision of on-site dental care services.

10. Whilst agreeing that the Pilot Project could help improve oral health and dental care for the needy elderly residing in RCHEs or receiving services in DEs, Dr PAN held the view that the Pilot Project should also cover elderly people who opted for subsidized home-based community care and support services.

11. SFH advised that it was practically impossible to provide on-site dental services to elderly people staying at home. Where dental treatments were required by these elderly people, community nurses who paid outreach visits to these elderly people could help make arrangements for them to receive such treatments at dental clinics in the community. Dr PAN said that consideration could be given to arranging these elderly people to receive on-site dental care services at district elderly centres.

12. In response to Ms Audrey EU's enquiry as to whether the Pilot Project would cover RCHEs and DEs in all districts, SFH replied in the affirmative. He further advised that selected NGOs would be engaged to provide outreach dental care and oral health care services to RCHEs/DEs primarily according to assigned district(s). Depending on the responses of interested NGOs in participating in the Pilot Project and subject to prior approval from the Government, selected NGOs might also provide services to RCHEs and/or DEs which were under their aegis but outside their assigned district(s). Ms EU requested the Administration to provide in writing information on distribution of service users by districts in due course.

Coverage of the outreach dental care services

13. Whilst welcoming an increase in resources for improving the oral health of the elderly, Ms LI Fung-ying considered that there was a mismatch of resources in meeting the need of the elderly. She pointed out that the most common oral health problem facing the elderly was tooth loss. The on-site dental care services to be provided for the IOPs and DE service users included dental check-up, scaling, polishing, as well as other

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necessary pain relief and emergency dental treatments, but not teeth replacement.

14. SFH advised that the Administration was well aware of the impact of tooth loss on the health of the elderly. Apart from providing free primary dental care services to IOPs and DE service users, the selected NGOs were also required to provide necessary assistance to those in need of and suitable for further follow-up curative dental treatments. Consultant i/c Dental Service of the Department of Health ("Consultant i/c DS, DH") supplemented that over 70% of elderly people residing in RCHEs were CSSA recipients. They were eligible for the special grant for dental treatment ("dental grant") provided under the CSSA Scheme to cover the expenses of dental treatments. Hence, the selected NGOs could provide curative dental treatments to those elderly people who were on CSSA, with the costs involved met through the dental grant under the CSSA. Where the curative treatments required more sophisticated support and had to be undertaken in dental clinics, the selected NGOs would provide or arrange to provide suitable transportation and escort services for the concerned IOPs and DE service users.

15. Mr Albert CHAN asked whether the Administration would pledge to provide the some 100 000 IOPs in RCHEs and DE service users with dentures within the three-year pilot period.

16. SFH responded that it was difficult to estimate the number of elderly people who would require dentures before the launch of the Pilot Project as the need to receive such treatment had to be based on the assessment and professional judgement of the dentists of the outreach dental teams. SFH reiterated that the selected NGOs would be required to arrange for the elderly the necessary follow-up curative treatments. For elderly people on CSSA, the cost of treatment would be covered by the dental grant. For non-CSSA recipients, NGOs would consider providing or arrange to provide financial assistance to those in financial difficulties to pay for the treatment.

17. Mr CHEUNG Man-kwong said that according to the Department of Health ("DH"), some 200 000 elderly people were edentulous or only had retained roots. Based on the assumption that the expenses for replacing a missing tooth were about $2,000, Mr CHEUNG asked whether consideration could be given to providing each of these elderly people by batches throughout a four-year period a subsidy of $10,000 for them to replace five or six missing teeth.

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18. Consultant i/c DS, DH advised that study of DH showed that only 2.8% of IOPs had regular dental checkups. This was due to the fact that a majority of IOPs were frail elderly and their physical conditions had made it difficult for them to access dental services outside RCHEs. However, dentists seldom provided outreach services at RCHEs. In the light of this, priority was given to improving oral health of and dental care for needy IOPs and service users in DEs. He noted that where dental grant was approved under the CSSA mechanism, the amount was adequate to meet the actual expenses of required curative dental treatments, which in some cases could be up to $10,000 for extensive treatments. Mr CHEUNG remarked that in these circumstances, these elderly people could receive the curative treatments subject to assessment and professional judgement of the dentists of the outreach dental teams.

Participation of NGOs

19. Mr CHAN Kin-por asked how the Administration could ensure that there would be sufficient number of NGOs participating in the Pilot Project. He further expressed concern about whether there were adequate resources for the selected NGOs to implement the Pilot Project so that they would not need to bear the cost out of their own pocket. Ms Audrey EU raised similar concern.

20. SFH responded that about 20 NGOs were currently operating dental clinics and/or providing outreach dental services to the public. The Administration had consulted potential NGOs on the Pilot Project and its current estimation was that there should be sufficient interest from NGOs to participate in the Pilot Project. As regards the resources for the selected NGOs, SFH advised that each outreach dental team would be provided with: an operating sum of about $900,000 subject to its meeting the minimum target of serving 2 000 IOPs and/or DE service users and conducting 30 seminars each year; an annual subsidy of about $180,000 subject to the engagement of a dentist meeting the prescribed requirements for each outreach team; as well as a one-off capital grant of up to $150,000 and capped at 50% of the dental and computer equipment purchase cost.

21. In response to Dr Joseph LEE's enquiry as to whether additional subvention would be provided to those selected NGOs which served more than 2 000 IOPs and/or DE service users each year, SFH said that 2 000 users was a minimum target. There was no limit on the number of outreach dental teams a selected NGO could form and an operating sum of about $900,000 would be provided to each team subject to its meeting of the specific service targets.

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22. Mr CHAN Kin-por expressed concern about the availability of a sufficient pool of registered dentists for the formation of outreach dental teams. SFH responded that there were at present some 50 local dentist graduates each year. In addition, there was a yearly supply of about 10 overseas graduates who had passed the licentiate examination. The selected NGOs would be encouraged to give priority in engaging dentists who had three years' working experience or less so as to enhance the training opportunities for young dentists. Mr WONG Kwok-hing called on the Administration to plan ahead for the supply of registered dentists to facilitate future expansion of the scope of the Pilot Project.

23. Mr WONG Kwok-hing asked whether the subvention for the selected NGOs was to be provided by the Food and Health Bureau or the Labour and Welfare Bureau. SFH responded that the Pilot Project, which aimed at enhancing primary care and improving oral health and dental care for the needy elderly, was under the purview of the Food and Health Bureau.

Service monitoring

24. Noting that there was a discrepancy of 20 000 elderly people between the expected number of elderly people to be benefited from the Pilot Project and the number of places or service capacity of RCHEs and DE as set out in paragraph 16 and Annex B of the Administration's paper respectively, Dr Joseph LEE enquired about the reason for the discrepancy. Dr LEE further asked about the estimated unit cost for providing on-site primary dental care services to each IOP/DE service user and the indicators to measure the cost-effectiveness of the services provided by the selected NGOs.

25. SFH explained that the operating sum of $900,000 should be able to cover the cost for providing on-site primary dental care services and conducting seminars. NGOs have also expressed willingness to provide their own charity funding to fund, partly or fully, the costs for providing further curative treatments to non-CSSA, needy elderly people. On the monitoring of the cost-effectiveness of the services provided by the selected NGOs, SFH advised that selected NGOs would be required to submit to the Government annual reports, audited financial statements and financial reports of the Pilot Project under their charge.

Conclusion

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26. In closing, the Chairman requested the Administration to provide

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after the launch of the Pilot Project in April 2011 information on the list of NGOs providing services under the Pilot Project and a breakdown by districts of the number of RCHEs and DEs receiving the services; and to revert to the Panel one year after the launch of the Pilot Project on a review of its effectiveness.

## V. Primary care development strategy - Primary care campaign
(LC Paper Nos. CB(2)729/10-11(04) to (07)

27. SFH briefed members on the territory-wide Primary Care Campaign ("the Campaign") to be launched in March 2011 as part of the Government's primary care development strategy, details of which were set out in the Administration's paper (LC Paper No. CB(2)729/10-11(04)).

28. At the request of Mr Albert HO, SFH undertook to provide after the meeting his speaking note for members' reference.

(*Post-meeting note*: The speaking note of SFH was circulated to members vide LC Paper No. 845/10-11(01) on 11 January 2011.)

29. Members also noted the information paper provided by the Administration on the Telephone Appointment Services of general out-patient clinics under the Hospital Authority ("HA") and the initiatives to enhance chronic disease management on a pilot basis through public clinics (LC Paper No. CB(2)729/10-11(07)).

Definition and Chinese translation of the term "primary care"

30. Ms Audrey EU asked the Administration whether it would change the Chinese translation of the term "primary care" from "基層醫療" to "家庭醫生服務", as the former might cause misunderstanding by the public that it was referring to healthcare services provided to the grassroots. Mr CHAN Kin-por raised similar concern. Dr Joseph LEE opined that the Administration should refer to the services as "community medical care", as emphasis had been placed on the provision of medical care services by family doctors.

31. SFH responded that "基層醫療" was already widely used locally for many years and also adopted by some overseas health authorities. The Administration would explain to the public what constituted primary care through enhanced publicity. SFH further advised that primary care referred to the first point of contact for individuals and families in a

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continuing healthcare process. It covered a wide range of services which included the delivery and provision of health promotion; prevention of acute and chronic diseases; health risk assessment and disease identification; treatment and care for acute and chronic diseases; self-management support; and rehabilitative, supportive and palliative care for disabilities or end-stage diseases. At the initial stage, the Campaign would focus on promoting the primary care services provided by family doctors and dentists. There would be greater involvement in the Campaign of other healthcare professionals as part of the primary care team progressively.

Promotion of the family doctor concept

32. Noting that the Primary Care Directory ("the Directory") to be launched in 2010-2011 would provide personal and practice-based information (including services provided and the price range) of individual doctors and dentists, Mr CHAN Hak-kan enquired about -

(a) the requirements for enrolment in the Directory; and

(b) whether, and if so, when information of the Chinese medicine practitioners would be included in the Directory.

33. Dr Joseph LEE was also concerned about the timetable for inclusion of the information of other healthcare professionals in the Directory.

34. SFH responded that a more inclusive approach was adopted at the initial stage to invite doctors and dentists to enrol in the Directory. All registered doctors and dentists providing directly accessible, comprehensive, continuing and co-ordinated primary care services would be eligible for enrolment. SFH further advised that under the phased approach adopted for the development of the Directory, the first phase would cover doctors and dentists. As the next step, a sub-directory of Chinese medicine practitioners would be developed, to be followed by the development of the sub-directories of nurses and other allied health professionals.

35. In response to Dr PAN Pey-chyou's enquiry on the promotion of the family doctor concept to members of the public, SFH replied that the Directory would serve as a starting point for promoting the family doctor concept. Details of the Campaign, including the activities, target groups as well as the expected impact of the activities on healthcare professionals and the general public, were set out in Annex B to the Administration's paper.

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36. Mr Albert HO cast doubt on the effectiveness of the Directory in promoting the concept of family doctor and preventive care. He pointed out that in many overseas countries, there was a limit on the maximum number of patients each primary care practitioner could take care of so that the practitioners could effectively maintain a long-term and close relationship with the patients and assume the role of managers of care.

37. SFH responded that the emphasis of the Campaign was to change the healthcare seeking behaviour through education and promotion. The Administration had no intention of limiting patients' choice of doctors by any mandatory measures and hence, it was not desirable to mandatorily impose a limit on the number of patients a primary care practitioner could take care of. As a starting point, the Directory could facilitate members of the public to choose primary care providers who could serve them as family doctors. SFH stressed that any change of behaviour could not be made overnight or through mandatory measures alone. The proportion of the population having a family doctor for the provision of continuing and co-ordinated care was expected to increase from the current 20% to 30% to a higher level with the promotion of the family doctor concept.

38. Mr CHAN Kin-por called for greater effort from the Administration to engage family doctors to enhance communication with their patients, so that patients would have a better understanding of their diseases. This could foster the development of a close partnership between family doctors and patients and in turn change the existing habit of doctor-shopping.

39. Given that enrolment in the Directory was on a voluntary basis, Ms LI Fung-ying asked the Administration how it could attract family doctors to enrol in the Directory.

40. SFH responded that the Administration had consulted the Hong Kong Medical Association, the Hong Kong Doctors Union and The Hong Kong College of Family Physicians and they had indicated support for the development of the Directory. The promotion of the family doctor concept through the various publicity activities to be rolled out under the Campaign could also incentivize doctors and dentists to enrol in the Directory.

Collaboration among different primary care providers

41. Pointing out that Chinese medicine practitioners were the principal alternative primary care providers in Hong Kong, Dr PAN Pey-chyou asked whether consideration could be given to reviewing the current policy

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of HA of not allowing referral from public Chinese medicine clinics to public specialist out-patient clinics.

42. SFH responded that the establishment of a referral system between the Chinese and the Western medicine sectors required mutual understanding and acceptance of each other's profession. It was expected that the development of the Directory and the launch of the Campaign could encourage co-ordination among different primary care providers, including Chinese and western medicine practitioners, to provide multi-disciplinary and co-ordinated services.

Establishment of community health centres and networks

43. Mr WONG Kwok-hing enquired about the mode of service and the service capacity of the first purpose-built community health centre ("CHC") in Tin Shui Wai.

44. Mr CHAN Kin-por asked whether the CHC in Tin Shui Wai would adopt a case management approach and whether its mode of service would be extended to other districts.

45. SFH responded that the CHC in Tin Shui Wai aimed to provide one-stop, better co-ordinated, more comprehensive and multi-disciplinary primary care services to the public. SFH further said that the development of such a new health facility with different healthcare services co-located in the same building was only one of the many different models of CHC; other CHC pilot projects could be in the form of creating virtual networks among different primary care providers of close proximity in the community.

46. Chief Manager (Primary and Community Services), HA supplemented that the main focus of the services provided by HA's general out-patient clinic located in the CHC in Tin Shui Wai would be on the management of chronic diseases. This included the implementation of a multi-disciplinary risk assessment and management programme, under which multi-disciplinary teams of professional healthcare personnel including nurses, physiotherapists, dieticians, etc. would be set up to provide comprehensive health risk assessments for diabetes mellitus ("DM") and hypertension ("HT") patients so as to provide appropriate control of disease conditions and follow-up to patients. In addition, a Nurse and Allied Health Clinic would be established to provide high-risk chronic disease patients with more focused care in areas such as fall prevention, handling of respiratory problems, wound care, continence care, drug compliance and mental

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wellness. It was expected that the CHC in Tin Shui Wai would serve a total of 40 000 attendances in 2012-2013.

Subsidization for preventive care

47. Ms Audrey EU expressed concern about the effectiveness of the steps to be taken to promote primary care having regard to the low take-up rates for some pilot projects, such as the Elderly Health Care Voucher Pilot Scheme and the Shared Care Programme, which also aimed to promote primary care through the provision of subsidy.

48. SFH responded that the Administration would continuously review the effectiveness of those pilot projects having regard to the feedback from the healthcare service providers and the patients.

Role of DH

49. Dr Joseph LEE enquired about the role of DH in promoting the development of primary care.

50. SFH advised that a Primary Care Office had been set up under DH to support the planning, implementation and overall co-ordination of the long-term development of primary care. In particular, the Primary Care Office would assume the role of co-ordinating territory-wide development in primary care and service delivery, as well as strengthening collaborative efforts among various healthcare providers and with the community through platforms such as CHC and the Health City projects.

Resources for the development of primary care

51. Holding the view that better access to primary care services could promote the public's awareness to prevent diseases and thereby reduce the need for more intensive medical care and improve the efficiency of the healthcare system as a whole, Mr LEE Wing-tat asked -

(a) whether consideration could be given to providing free basic body checkup to members of the public at the age of 50 to 55 for early detection of cardiovascular diseases, DM and HT; and

(b) what was the respective percentage of the expenditure on primary care as a percentage of the government's total expenditure and the Gross Domestic Product.

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52. SFH responded as follows -

(a) the Administration attached great importance to the development of holistic primary care, especially preventive care and wellness promotion. For instance, DH had been conducting studies on the health status of the local population, such as population health surveys, and rolling out vaccination subsidy schemes for different target groups. It should however be pointed out that individuals should be responsible for their own health. Hence, one of the primary care initiatives was the development of a set of reference frameworks for DM and HT care in primary care settings so as to, amongst others, raise the public's awareness of the importance of preventing and properly managing these diseases which were the two most common chronic diseases in Hong Kong; and

(b) healthcare resources had to be utilized in a prudent manner with maximal effect of healthcare. Apart from promoting preventive care, it was necessary for the Administration to maintain adequate resources to ensure wide public access to costly medical treatment. At present, public health/primary care/general out-patient services roughly accounted for 10% of government's health expenditures, and the rest, including mainly hospital and specialised care, for another 90% in broad terms. For the total health expenses, about half was public spending and the other half private spending which included the cost of purchasing medical insurance and seeking curative care on an episodic basis.

53. In response to Mr Albert CHAN's enquiry about the resources allocated for primary care, SFH advised that an additional funding of about $4.1 billion had been allocated or earmarked for primary care and public-private partnership in healthcare from 2007-2008 to 2013-2014.

54. Mr Albert CHAN opined that the resources allocated were far from adequate to meet the healthcare needs of the public. Whilst expressing support for primary care development, he surmised that the initiatives to promote individuals to undertake preventive care through family doctors in the private sector would result in a shift of the government's commitment to healthcare to the private sector. In the end, patients had to pay for the treatment of the health problems so detected through their own means.

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55. SFH advised that there was no question of the government shifting its commitment to healthcare to the private sector, as evident by the fact that the government had been providing and would continue to provide financial support to the long-term development of primary care. The promotion of having a family doctor as long-term health partner was in line with the principle that healthcare was a shared responsibility. The initiatives could also enhance the monitoring of the provision of primary care services in the private sector and encourage family doctors to undergo continued professional training.

Evaluation

56. Mr Albert CHAN asked whether the Administration would conduct a review two to three years after the implementation of the primary care development strategy to fine-tune the development plans.

57. SFH responded that developing primary care was an on-going and evolving process. The Administration had adopted a step-by-step and consensus-building approach to reform the primary care system so that a virtuous cycle of pilot-evaluation-adjustment could be established for the continuous development and implementation of primary care initiatives.

## VI. Online checking of the eligibility of non-permanent Hong Kong Identity Card holders for subsidized public healthcare services

(LC Paper Nos. CB(2)729/10-11(08) and (09) and CB(2)794/10-11(01))

58. Under Secretary for Food and Health ("USFH") briefed members on the Government's proposal to implement an electronic system to conduct online checking of the eligibility of non-permanent Hong Kong Identity Card ("HKIC") holders for subsidized public healthcare services, details of which were set out in the Administration's paper (LC Paper No. CB(2)729/10-11(08)). Director (Cluster Services), HA, Assistant Director of Health (Special Health Services) and Assistant Director (Information Systems) then gave a PowerPoint presentation on the existing procedures of patient registration in public hospitals/clinics under HA and DH, as well as the operation of the proposed electronic checking system, details of which were set out in the presentation materials tabled at the meeting (LC Paper No. CB(2)794/10-11(01)).

59. At that juncture, the Chairman decided to extend the meeting for 15 minutes beyond its appointed time to allow more time for discussion.

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60. Mr CHAN Kin-por expressed concern about the cost incurred in the implementation of the proposed electronic checking system. He enquired whether it was feasible to restrict the access rights of authorized persons of HA and DH to the relevant data repository held by the Immigration Department ("ImmD") instead of installing a new electronic system in ImmD.

61. USFH responded that when exploring possible options to plug the existing loophole, the Administration had to be mindful of the need to protect the personal data privacy and security of members of the public as well as the principle that the use of any data held by ImmD should only be for the purposes for which it was collected. Given the massive volume of daily uses of the public healthcare services, and the need to provide an instant return to the public hospitals and clinics upon receipt of requests for checking the eligibility of non-permanent HKIC holders for subsidized healthcare services, USFH advised that the proposed system was considered the most preferred option as it could achieve a proper balance among the above objectives.

62. USFH further advised that the proposed electronic system would ensure that non-residents using the subsidized public healthcare services would be charged at Non-eligible Persons rates, thereby providing safeguards against potential loss of Government revenue. Based on the annual potential revenue loss of about $20.8 million under the existing arrangement, the total cost of the proposed system would be offset in a few years time by the potential revenue loss avoided after implementation of the proposed electronic system. It should also be noted that $17 million (i.e. the resources required for upgrading the information system in HA) out of the one-off capital cost of $34.5 million would be absorbed by the annual subvention to HA under the block vote for information system.

63. Mr IP Kwok-him enquired whether the annual revenue loss was an actual figure or an estimation only.

64. USFH replied that as HA and DH was unable to verify the eligibility of non-permanent HKIC holders for subsidized public healthcare services under the existing arrangement, the amount of a loss of about $20.8 million per annum was an estimation based on the results of two rounds of survey conducted jointly by ImmD and HA in December 2009 and January 2010 for the purpose of assessing the magnitude of the problem. It was found that during the one-week and the one-month period covered by the first and the second survey respectively, around 0.05% of the HKIC holders

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who accessed HA's services had their validity of stay expired and were not eligible for the services at subsidized rates.

65. Mr IP was concerned about whether non-residents would be denied public healthcare services in urgent cases because of their lack of means. USFH advised that it was the Administration's long-standing policy that no patients would be denied adequate medical treatment due to lack of means.

66. Whilst recognizing the need for setting up the proposed checking system, Mr Albert CHAN considered it necessary to ensure that only data vital to the verification of a person's eligibility for subsidized public healthcare services would be exchanged between HA/DH and ImmD to protect privacy of an individual.

67. USFH advised that under the proposed checking arrangement, the data to be inputted by HA/DH staff to the system would only be the card number of the non-permanent HKIC holders whose card carried a "C" code (i.e. whose stay in Hong Kong was limited by the Director of Immigration at the time of their registration) or "U" code (i.e. whose stay in Hong Kong was not limited at the time of registration but whose validity of stay would expire upon their departure from Hong Kong for more than 12 months). The information provided by ImmD in return would be whether the cardholder had a valid resident status on the day.

68. Mr Albert CHAN asked whether the proposed system could verify the resident status of those permanent residents who lived outside Hong Kong and had lost their HKIC. At present, these persons would need to pay for the fees for Non-eligible Persons when accessing public healthcare services. Director (Cluster Services), HA responded that persons who had lost their HKIC could provide supporting materials, such as the card number and document issued by ImmD showing that an application for a replacement card was being processed, to prove their eligibility for subsidized public healthcare services.

69. In view of the rapid advancement in technology, Dr PAN Pey-chyou enquired whether there would be a need to upgrade the proposed system soon after its implementation. USFH advised that the Administration did not see a need at that stage.

70. In closing, the Chairman said that members of the Panel were in support of the proposal to implement an electronic system to conduct online checking of the eligibility of non-permanent HKIC holders for subsidized public healthcare services.

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## VII. Any other business

71. The Chairman reminded members that the Panel would next meet on 17 January 2011 at 10:45 am to receive views from deputations on the commencement of the provisions related to proprietary Chinese medicines in the Chinese Medicine Ordinance (Cap. 549).

72. There being no other business, the meeting ended at 10:42 am.

Council Business Division 2
Legislative Council Secretariat
11 February 2011