立法會
Legislative Council

LC Paper No. CB(2)1087/14-15
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 21 July 2014, at 4:30 pm
in Conference Room 3 of the Legislative Council Complex

Members present	**:** Dr Hon LEUNG Ka-lau (Chairman) Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN (Deputy Chairman) Hon Albert HO Chun-yan Hon Vincent FANG Kang, SBS, JP Hon WONG Ting-kwong, SBS, JP Hon CHAN Kin-por, BBS, JP Dr Hon Priscilla LEUNG Mei-fun, SBS, JP Hon CHEUNG Kwok-che Hon Mrs Regina IP LAU Suk-yee, GBS, JP Hon Albert CHAN Wai-yip Hon Charles Peter MOK, JP Hon CHAN Han-pan, JP Hon Alice MAK Mei-kuen, JP Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung Dr Hon Helena WONG Pik-wan Dr Hon Elizabeth QUAT, JP Hon POON Siu-ping, BBS, MH Dr Hon CHIANG Lai-wan, JP
Member attending	**:** Hon Michael TIEN Puk-sun, BBS, JP

Public Officers attending : Item II

Dr KO Wing-man, BBS, JP
Secretary for Food and Health

Dr Constance CHAN Hon-yee, JP
Director of Health

Mr Chris SUN Yuk-han, JP
Head, Healthcare Planning and Development Office
Food and Health Bureau

Dr Amy CHIU Pui-yin, JP
Assistant Director of Health (Health Administration and Planning)

Items III and IV

Professor Sophia CHAN Siu-chee, JP
Under Secretary for Food and Health

Item III

Ms Angela LEE
Principal Assistant Secretary for Food and Health (Health) 2

Dr CHEUNG Wai-lun
Director (Cluster Services)
Hospital Authority

Dr LO Su-vui
Director (Strategy and Planning)
Hospital Authority

Dr H C MA
Deputising Cluster Chief Executive (Kowloon West Cluster)
Hospital Authority

Dr Y K NG
Deputising Hospital Chief Executive (Kwai Chung Hospital)
Hospital Authority

Mr Donald LI
Chief Manager (Capital Planning)
Hospital Authority

Item IV

Miss Janice TSE Siu-wa, JP
Deputy Secretary for Food and Health (Health) 1

Dr Teresa LI Mun-pik
Assistant Director of Health (Family and Elderly Health Services)

Dr Rita HO Ka-wai
Principal Medical and Health Officer (Family Health Service)
Department of Health

Clerk in attendance : Ms Maisie LAM
Chief Council Secretary (2) 5

Staff in attendance : Ms Janet SHUM
Senior Council Secretary (2) 5

Ms Priscilla LAU
Council Secretary (2) 5

Ms Michelle LEE
Legislative Assistant (2) 5

Action

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

[LC Paper Nos. CB(2)1881/13-14(01), CB(2)2033/13-14(01), CB(2)2059/13-14(01) and CB(2)2079/13-14(01)]

Members noted the following papers issued since the last meeting -

(a) Referral from the Public Complaints Office of the Legislative Council ("LegCo") Secretariat on the services of Government Dental Clinics and public General Out-patient Clinics;

(b) Letter dated 9 July 2014 from Dr KWOK Ka-ki on the incident regarding the use of expired surgical sutures at the Queen Elizabeth Hospital;

(c) Information paper provided by the Administration on the mechanism put in place by the Hospital Authority ("HA") to ensure safety in the use of medical equipment and products; and

Action

(d) Referral from the Public Complaints Office of the LegCo Secretariat on the policy on rare diseases.

2. On items (b) and (c) above, members agreed to include the subject "Mechanism put in place by the Hospital Authority to ensure safety in the use of medical equipment and products" in the Panel's list of outstanding items for discussion. The Chairman suggested that the Queen Elizabeth Hospital should test the bacteria culture and quality of the expired surgical sutures in question. Secretary for Food and Health ("SFH") undertook to relay the suggestion to HA for consideration.

II. Regulation of private healthcare facilities

[LC Paper Nos. CB(2)1963/13-14(01) to (03), CB(2)2013/13-14(01) and CB(2)2048/13-14(01) to (02)]

3. SFH briefed members on the progress of the work and the major recommendations proposed by the working groups set up under the Steering Committee on Review of Regulation of Private Healthcare Facilities ("the Steering Committee"), details of which were set out in the Administration's paper (LC Paper No. CB(2)2048/13-14(01)).

4. Members noted the background brief entitled "Regulation of private healthcare facilities" (LC Paper No. CB(2)2048/13-14(02)) prepared by the LegCo Secretariat.

5. Members also noted the two letters dated 27 June 2014 from Dr KWOK Ka-ki and Dr Helena WONG respectively, and another two letters dated 2 July and 4 July 2014 from Miss Alice MAK and Mr Vincent FANG respectively (LC Paper Nos. CB(2)1963/13-14(01) to (03) and CB(2)2013/13-14(01)) concerning the regulation of private healthcare facilities in view of a recent fatal incident involving liposuction.

Regulation of private hospitals

Corporate governance

6. Referring to the recommendation proposed by the Working Group on Regulation of Private Hospitals ("Working Group 4") that private hospitals should introduce a complaints handling system to manage complaints, Miss Alice MAK opined that clear guidelines should be put in place to ensure that complaints lodged by patients or their representatives against the service of private hospitals would be handled properly.

Action

7. SFH advised that at present, while the Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes issued by the Department of Health ("DH") required private hospitals to put in place a mechanism for handling complaints made by aggrieved parties, there was an absence of a set of unified protocol for private hospitals to handle complaints. Working Group 4 had recommended that, with reference to the two-tier complaints management system adopted by the Hospital Authority ("HA"), a two-tier complaints handling system be established to handle all complaints against private hospitals. The first-tier complaints management should be at the service delivery level at which private hospitals would be required to manage complaints at source according to a standardized mechanism prescribed by DH. The second-tier should handle unresolved cases according to a centralized and independent mechanism.

Clinical governance

8. Prof Joseph LEE cast doubt over the willingness of private hospitals to subject to an enhanced regulatory regime. In particular, he was concerned about the regulatory control over those medical procedures performed by visiting doctors of private hospitals. SFH advised that the Administration had maintained communication with the relevant sectors in hammering out the revamped regulatory regime for private healthcare facilities. The Hong Kong Private Hospitals Association welcomed the Administration's initiative to improve the regulation of private hospitals, so as to safeguard the interests of patients. On the credentialing of visiting doctors of private hospitals, it was proposed that private hospitals should put in place policies and mechanisms to ensure the competence of visiting doctors. Separately, the Hong Kong Academy of Medicine ("HKAM") was in the process of establishing a credentialing system on certain key medical procedures.

9. On the recommendation of Working Group 4 that a sentinel events reporting system should be established to enhance clinical governance of private hospitals, Miss Alice MAK was of the view that requiring private hospitals to report all sentinel events on a mandatory basis should be a component of the reporting system. SFH advised that the power of DH in prescribing the reporting requirements and gaining access to records kept by the private hospitals in connection with sentinel events would be enhanced under the revamped regulatory regime.

Price Transparency

10. Dr Fernando CHEUNG sought clarification as to whether the measures proposed to enhance price transparency of private hospitals under the revamped regulatory regime (such as the offering of Recognized Service

Action

Packages ("RSP") by private hospitals) were aimed at providing greater budget certainty to consumers not covered by private health insurance ("PHI"), whereas the interest of PHI policyholders using private hospital services would be safeguarded under the regulatory regime for the proposed Health Protection Scheme ("HPS").

11. SFH advised that the direction of healthcare reform was aimed at ensuring the sustainability of the dual-track healthcare system comprising both public and private sectors. The public healthcare system was the cornerstone of Hong Kong's healthcare system and the safety net for all. A number of public hospital redevelopment or expansion projects were now underway to meet the medical needs of the community. To maintain the balance between public and private healthcare sectors, there was a need to enhance the use of private healthcare services. The proposed HPS was meant to provide more choices, better protection as well as an alternative to those who might afford and were willing to purchase PHI and made use of private healthcare services. On the other hand, there was a genuine need to strengthen the regulation for and enhance the standards of private hospitals, which included, among others, the regulatory aspect of price transparency in order to provide greater budget certainty to consumers. This in turn would enhance consumer confidence in using private healthcare services and contribute to achieving the policy objectives of the proposed HPS.

12. Mr CHAN Kin-por expressed support for the recommendations put forward by Working Group 4 to enhance the regulatory regime for private hospitals, in particular those concerning the enhancement of price transparency. He opined that apart from regulation, there should also be an increase in the number of private hospital beds to increase market competition and hence, help to lower the charges of private hospitals.

13. Mr Albert HO remarked that while it was not appropriate for the Administration to interfere with the charging of the profit-making private hospitals which should be determined by market forces, the Administration should ensure that the level of charges of those non-profit-making private hospitals operated on lands which were granted by the Government at nil or nominal premium was affordable to the general public in view of the Government revenue foregone. Casting doubt about the effectiveness of the proposed measure of requiring private hospitals to disclose its fee schedule in lowering the charges of private hospitals and bringing benefits to the public, he asked whether consideration could be given to scraping the policy of direct land grant for private hospital development and injecting the revenue from land sale for private hospital development into a fund for providing direct subsidy to local residents using private hospital services. Expressing concern that the existing power of DH in accessing the financial

Action

records of private hospitals was limited, Dr KWOK Ka-ki echoed Mr Albert HO's view.

14. SFH advised that upon completion of the new private hospital at Wong Chuk Hang and redevelopment of existing hospitals, the capacity of private hospitals would be increased in the next few years. He explained that the crux of the existing problem of private hospital charges laid in the lack of upfront cost certainty. Under the proposed uniform quotation system, patients having investigative procedures or elective, non-emergency therapeutic operations or procedures for known diseases should be informed of the estimated total charges on or before admission to private hospitals. Private hospitals would also be encouraged to offer RSP, which were identically and clearly defined standard services provided at packaged charge for common operations or procedures on known diagnosis, for easy consumption of the public. In addition, private hospitals would be required to make public the key historical statistics on their actual bill sizes for common treatments or procedures. It should also be noted that under the revamped regulatory regime, DH would be empowered to have access to records and documents, including the financial information, of private hospitals. It was expected that the implementation of these proposed measures, coupled with the enhanced private healthcare capacity, would better enable the insurers to negotiate with the private hospitals under the proposed HPS to further enhance transparency and certainty of upfront payment by consumers.

15. SFH further advised that the current-term Government's policy on private hospital development was to facilitate private hospital development by non-profit-making organizations, such as non-governmental organizations and universities, to cater for the healthcare needs of the middle class, but not the rich and the affluent. Given that the construction of hospital building would involve a huge capital outlay, the Administration would consider granting loans to organizations in obtaining the necessary capital funding in financing the development of new non-profit-making private hospitals. A set of special requirements would be imposed on the hospital development to help achieve the above policy objective, such as ensuring price transparency and that services in packaged charge would be offered. To facilitate monitoring of the operation of these hospitals, the organizations concerned would be required to enter into a service deed with the Government, as was the case of the land disposal arrangement for the development of a new private hospital at Wong Chuk Hang.

16. In response to Dr KWOK Ka-ki's concern about the availability of sites for the development of new non-profit-making private hospitals, SFH advised that upon completion of new private hospital(s) and redevelopment

Action

of existing hospitals, it was expected that the capacity of private hospitals would be increased by 30% to 40 % in 2020.

Sanctions

17. In response to Dr KWOK Ka-ki's enquiry about whether sanctions for private hospitals not complying with the requirements under the revamped regulatory regime would be enhanced, SFH responded in the positive, adding that the sanctions could take the form of fines and/or imprisonment.

Private hospitals operated by charitable bodies

18. Mr CHAN Kin-por asked whether the revamped regulatory framework for private hospitals would address the problem that some private hospitals operated by tax-exempt charitable bodies had distributed their profits to staff members in the form of bonus and/or carried out activities incompatible with the charitable objects stated in their governing instruments. Mr Albert HO expressed concern that some tax-exempt private hospitals had exploited grey areas under existing laws in distributing their profits. SFH advised that the monitoring of whether the profits of these private hospitals were applied for charitable purposes fell outside the purview of the regulatory regime for private hospitals.

Regulation of facilities providing high-risk medical procedures in ambulatory setting

19. Miss Alice MAK called on the Administration to expedite the introduction of a comprehensive regulatory regime to regulate the facilities providing high-risk medical procedures, so as to avoid the recurrence of the two adverse incidents causing casualties resulting from advanced therapies and liposuction performed in ambulatory setting in October 2012 and June 2014 respectively. In her view, these adverse incidents were caused by professional misconduct on the part of the medical practitioners concerned. Dr KWOK Ka-ki held another view. He considered that the crux of the problem laid in the lack of regulation over the beauty industry such that unscrupulous traders could employ medical practitioners and use beauty services companies as a front to improperly perform high-risk medical procedures. The medical practitioners employed by these companies were always in a weak bargaining position in determining the appropriateness of a treatment.

20. Expressing concern about the adverse incident in June 2014 whereby a woman died shortly after undergoing liposuction at a hair transplant centre, Dr Helena WONG urged the Administration to step up its efforts to enhance

Action

the regulation of the premises, the personnel and the devices involved in the provision of high-risk medical procedures to safeguard public health. Mr Vincent FANG sought information about whether the hair transplant centre concerned was registered as a business or a medical clinic and, if it was the former, whether the holder of the business registration certificate was a registered medical practitioner. He was also concerned about whether the medical practitioner performing the procedure was an employee of the hair transplant centre, or the centre had referred the client concerned to the medical practitioner for service.

21. While pointing out that it was not appropriate for him to elaborate the case in detail as it was under investigation, SFH affirmed that liposuction was a medical procedure and should be performed by registered medical practitioners. It should, however, be noted that the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) and the Medical Clinics Ordinance (Cap. 343), which had undergone no substantive amendments since 1960s, only set out the respective regulatory framework for private hospitals, nursing homes and maternity homes, and non-profit-sharing medical clinics. Medical clinics operated by medical groups or individual medical practitioners were not subject to direct statutory control beyond regulation of individuals' professional practice by the Medical Council of Hong Kong. Hence, any registered medical practitioners with a valid practice certificate could offer and perform high-risk medical procedures in an ambulatory setting in whatever way and form they deemed appropriate.

22. SFH further advised that given the increasing trend for ambulatory surgery procedures performed outside the hospital setting, it was proposed that ambulatory facilities where high-risk medical procedures were performed should be regulated by a statutory registration system. These regulated ambulatory facilities should be subject to a set of core facility standards and requirements that covered the management of the facility, physical conditions, service delivery and care process, infection control and resuscitation and contingency. Whether a medical procedure should be classified as a high-risk procedure would be determined by criteria set out in respect of risk of procedures; risk of anaesthesia involved; and patient's conditions. A medical procedure was classified as high-risk and should be performed only by qualified health professionals if the procedural risk was high, if the risk of anaesthesia involved was high, or if the patient's condition was classified as unstable severe systemic disease (acute exacerbation) or worse.

23. Prof Joseph LEE cast doubt over the feasibility of the proposed registration system for facilities providing high-risk medical procedures in ambulatory setting. Dr KWOK Ka-ki maintained the view that there was a

Action

need to regulate the beauty industry and the misleading advertisement published by members of the trade. SFH explained that instead of regulating the beauty industry indiscriminately, the Administration had adopted a risk-based approach focusing on those procedures or treatments that were intrinsically risky and could cause considerable harm to clients if not properly administered by qualified personnel. As mentioned earlier at the meeting, the Working Group on Differentiation between Medical Procedures and Beauty Services ("Working Group 1") had identified certain cosmetic services which should be performed by registered medical practitioners or dentists because of the risks involved. Enforcement actions would be taken as necessary under the Medical Registration Ordinance (Cap. 161) and the Dentists Registration Ordinance (Cap. 156). The remaining practices of the beauty industry were non-intrusive and involved no or very little health risks that called for direct regulatory intervention.

24. While welcoming the proposed regulation of facilities providing high-risk medical procedures in ambulatory setting, Mr Vincent FANG asked whether there would be any regulatory control over the scope of medical services provided in other medical clinics. Mr Albert HO raised a similar question. SFH clarified that the revamped regulatory regime only proposed, among others, ambulatory facilities where high-risk medical procedures were performed be subject to statutory registration requirement in order to better safeguard patient safety. Expert advice from HKAM would be sought on the lists of high-risk procedures. Medical clinics owned, managed, operated and serviced solely by identical registered medical practitioners that did not provide high-risk procedures would not be subject to additional registration requirement beyond registration of individual medical practitioners.

Differentiation between medical procedures and beauty services

25. Mr POON Siu-ping enquired about the number of beauty practitioners involved in the provision of the 35 cosmetic procedures with potential safety concerns identified by Working Group 1 as set out in Annex II to the Administration's paper.

26. SFH advised that Working Group 1, having examined the health risks of those 35 cosmetic procedures, had recommended that 15 of these procedures should be performed by registered medical practitioners or dentists because of the risks involved. With the endorsement of the Steering Committee, DH had issued advisory notes in November 2013 to both the beauty industry and medical profession to remind practitioners of these requirements when providing cosmetic services. Most of the remaining 20 procedures were cosmetic procedures involving the use of medical devices, particularly energy emitting devices. The Steering Committee

Action

agreed that the regulation of these procedures should be deliberated within the proposed regulatory framework for medical devices currently under review.

27. Referring to a recent media report of a suspected case of illegal practice of medicine involving injection of Botox, the Chairman asked whether there was any mechanism in place to refrain the person concerned from performing the relevant procedure. SFH advised that the performance of those cosmetic procedures that were classified as medical procedures (such as procedures that involved injections) by non-medical practitioners would render oneself liable for offences under the Medical Registration Ordinance. DH would refer any suspected illegal practice of medicine to the Police for further investigation. Citing the adverse incident causing casualties resulting from advanced therapies in ambulatory setting in October 2012 as an example, Miss Alice MAK urged the Administration to expedite prosecution against illegal practice of medicine.

28. In response to Dr KWOK Ka-ki's enquiry on the number of inspection to beauty services companies conducted by DH and the enforcement actions taken against the non-compliance cases, Director of Health advised that DH had screened more than 16 000 advertisements, which involved some 90 beauty services companies, relating to the provision of cosmetic procedures with potential safety concerns during the period of October 2012 to June 2014. DH would take follow-up actions on those advertisements relating to procedures that involved injections. Any suspected violation of the Medical Registration Ordinance and the Dentists Registration Ordinance would be referred to the Police for investigation. DH had also collaborated with the Consumer Council to identify suspicious offences. Of the 87 cases referred to DH during the same period, no violation of these two Ordinances was found. As regards enforcement of the Undesirable Medical Advertisements Ordinance (Cap. 231), warning letters would first be issued to persons who had published or caused to publish the undesirable medical advertisements contravening the Ordinance. In case the persons concerned disregarded the warning and continued to publish or caused to publish the relevant advertisements, prosecution actions would be taken. During the period of October 2012 to June 2014, DH had issued 492 warning letters and initiated four prosecutions in relation to advertisements of beauty centres that had contravened the Ordinance.

Interim measures

29. Noting the Administration's plan to proceed to legislative procedures to enhance the regulation of private healthcare facilities in the 2015-2016 legislative session, Mr POON Siu-ping asked whether and, if so, what

Action

interim measures would be put in place to enhance the governance of these facilities for the benefit of the public. In particular, Dr Helena WONG was concerned about the interim measures to safeguard the safety of the public undergoing high-risk medical procedures in ambulatory setting. Holding the view that the adverse incidents causing casualties resulting from advanced therapies and liposuction performed in ambulatory setting in October 2012 and June 2014 respectively were both caused by professional misconduct on the part of the medical practitioners concerned, Mr Vincent FANG asked whether any measures would be put in place to define the scope of clinical practice of those medical practitioners practising in ambulatory facilities.

30. SFH advised that the Administration was considering the findings and recommendations of the Steering Committee and aimed to conduct a public consultation exercise by end 2014 on the revamped regulatory regime for private healthcare facilities. He assured members that subject to the outcome of the public consultation, the Administration would endeavour to expedite the drafting of the legislative proposal and submit it for scrutiny as soon as practicable. Prior to the introduction of the new regulatory regime, DH would review the Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes to enhance existing regulatory requirements in the regulatory regime for private hospitals. As regards the ambulatory facilities providing high-risk medical procedures, a voluntary administrative listing system would be introduced to monitor such facilities before the introduction of statutory registration. As mentioned earlier at the meeting, at professional level, a working group of HKAM was working on the level of credentialing required of certain key medical procedures. Prof Joseph LEE considered that the Administration should, in the meantime, step up public education in this regard and provide a list of cosmetic procedures that were classified as medical procedures, and medical procedures defined to be high-risk for reference of the public.

III. Redevelopment of Kwai Chung Hospital (Phase 1)

[LC Paper Nos. CB(2)2048/13-14(03) and (04)]

31. Under Secretary for Food and Health ("USFH") briefed members on the proposed redevelopment of Kwai Chung Hospital ("KCH"), Phase 1, details of which were set out in the Administration's paper (LC Paper No. CB(2)2048/13-14(03)).

32. Members noted the background brief entitled "Redevelopment of Kwai Chung Hospital" (LC Paper No. CB(2)2048/13-14(04)) prepared by the LegCo Secretariat.

Action

Project implementation

33. Mr Vincent FANG declared that he was the former Chairman of the Hospital Governing Committee of KCH & Princess Margaret Hospital ("PMH"). He noted that while renovation works would be carried out, among others, at Blocks L/M and J of KCH and Block N of PMH for decanting purposes under Phase 1 of the redevelopment project of KCH ("the project"), only Block L/M would be demolished under Phase 3 of the project. He considered that the design of the renovation works at Block J of KCH and Block N of PMH should take into account that these Blocks would be retained for use after completion of the project. Chief Manager (Capital Planning), HA ("CM(CP), HA") advised that the non-clinical facilities of KCH would temporarily be decanted to the renovated Block J of KCH and Block N of PMH during Phase 2 of the project. These facilities would subsequently be reprovisioned in the new hospital buildings of KCH upon their construction. According to the present plan, the future use of these two Blocks would be decided by PMH by then.

34. Expressing support for the project, Dr KWOK Ka-ki was concerned about whether the decantation and construction works would affect the existing patients staying at KCH such that they would be discharged from hospital even their clinical conditions were not suggestive of discharge. He considered that where necessary, arrangements should be made to enable the transfer of the affected patients to other psychiatric public hospitals during the project period.

35. USFH advised that the major inpatient and clinical services of KCH would be decanted to the decantation building to be constructed at the existing car park area of PMH and the renovated areas carried out in Phase 1 of the project. KCH would remain functional at all times and any disruption of services, if unavoidable, would be kept to a minimum. Deputising Hospital Chief Executive (KCH), HA ("DHCE(KCH), HA") supplemented that the number of inpatient beds in KCH would remain the same during the project period. He assured members that discharge of patients would be based on the clinical conditions of individual patients.

"Design and Build" mode

36. Noting that the project would be delivered in the "Design and Build" mode, Dr Fernando CHEUNG asked whether HA would require the contractor to gauge the views of patients and their family members to ensure that the design of the redeveloped KCH would meet patients' needs and improve the current unpleasant, repulsive and institute-like features of KCH, in particular the overcrowding conditions of the female inpatient units.

Action

37. CM(CP), HA advised that the total floor area of KCH would be increased by around 52% (i.e. from 88 000 square meters to 134 000 square meters) after redevelopment. This would enable the provision of space appropriate to patient and service needs, and respect the privacy and dignity of patients. CM(CP), HA added that the "Design and Build" mode could allow HA to take into account both aspects of design and price in the tender evaluation so that the best balance between the two could be achieved for the project. HA would engage KCH's frontline healthcare personnel, family members of its patients and patient groups in the process of drawing up the design brief for the redeveloped KCH. Their views would be incorporated as user requirements to be stipulated in the tender document and for guiding the subsequent detailed design by the successful tenderer.

Proposed model of psychiatric services at KCH

38. While expressing support for the project, Miss Alice MAK and Mr POON Siu-ping were concerned that the number of inpatient beds of KCH would only be increased from 920 to 1 000 beds upon completion of the project. They asked whether an addition of 80 beds would be sufficient to meet the mental health needs of the community. Holding the view that the admission and discharge of patients would unavoidably be associated with the number of inpatient beds available in the redeveloped KCH, Mr Albert HO asked whether the decision of providing 1 000 beds for acute, sub-acute, extended care, long stay and private patients at the redeveloped KCH had taken into account the population growth of, and the increasing psychiatric service need in, the Kowloon West Cluster ("KWC") in the next few decades.

39. USFH explained that the emphasis of modern psychiatric care had shifted from institutional hospital care to integration with community-based care. The redeveloped KCH would provide a more integrated patient-centred service with a balance of inpatient service, ambulatory care, community outreach services and in-reach service of partner organizations. DHCE(KCH), HA supplemented that with the development of different community and outreach programmes, such as the Case Management Programme for patients with severe mental illness, in recent years, the demand for inpatient care had remained steady. In the past three years, KCH recorded some 3 000 inpatient discharges each year and the bed occupancy rate stayed at around 77%. Against the above, and taking into account the factor of population growth, HA considered the number of additional inpatient beds at the redeveloped KCH reasonable.

40. Dr KWOK Ka-ki was of the view that more inpatient beds should be provided at the redeveloped KCH to meet the demand from the increasing

Action

population. These beds could be opened by phases. He sought clarification as to whether the psychiatric services of KCH covered only the population of KWC or the whole territory. Director (Cluster Services), HA ("D(CS), HA") responded that HA had published in 2011 the Hospital Authority Mental Health Service Plan for Adults 2010-2015 following a period of consultation among the stakeholders about the future mental health services in HA. The Plan guided the provision of psychiatric services in different hospital clusters. As regards the inpatient services of KCH, it should be noted that a considerable number of its inpatients were long-stay patients who had been hospitalized for more than one year. Efforts had been made in the past few years to facilitate these long-stay patients' discharge and re-integration into the community. This in turn increased the inpatient service capacity of KCH. The current staying period of inpatients was one month in average. DHCE(KCH), HA supplemented that a total of 580 and 131 patients were hospitalized in KCH for less than 12 months and more than one year respectively.

41. While expressing support for the new mental health service model which focused on community and ambulatory services so as to enhance patients' prospects of re-integration into the community after rehabilitation, Mr Albert HO held the view that its implementation required the availability of adequate community mental health services. Given the absence of a community treatment order, the inadequacy of halfway house places for discharged mental patients, the shortfall of community psychiatric nurses and social workers to provide outreach services and the short follow-up consultation time at psychiatric outpatient clinics, he cast doubt about whether HA should adopt the new service model in planning the number of inpatient beds to be provided in the redeveloped KCH. Miss Alice MAK expressed similar concern. Dr Fernando CHEUNG remarked that there was a lack of medical-social collaboration in the provision of community mental health services. The places of halfway houses for discharged mental patients and sheltered workshops were also far from adequate to meet the demand.

42. USFH advised that the Review Committee on Mental Health ("the Review committee"), which was chaired by SFH and comprised members with wide representation and representatives from the Labour and Welfare Bureau, Education Bureau, DH, Housing Department, Social Welfare Department ("SWD") and the Police, would consider, among others, means and measures to strengthen the provision of community mental health services.

43. Miss Alice MAK enquired about the need for providing private wards at the redeveloped KCH. DHCE(KCH) advised that at present, there were cases whereby patients who required psychiatric inpatient care refused to

Action

stay in KCH due to the lack of patient privacy at the inpatient wards. This made it difficult for HA to provide the most effective treatment for these patients. Hence, the design of the inpatient wards of the redeveloped KCH would enable flexible zoning to allow the provision of single-bed units. Miss Alice MAK remarked that ensuring improvement of the overcrowding conditions of all inpatient wards of KCH and adequacy of inpatient beds for non-private patients, rather than providing private inpatient wards, should be the first and foremost consideration of HA when planning the redevelopment of KCH. In response to Miss Alice MAK's enquiry as to whether private patients of the redeveloped KCH would be charged according to HA's fee schedule for private services, DHCE(KCH), HA responded in the positive.

44. Dr KWOK Ka-ki enquired about how patients would be benefited from the development of an ambulatory care centre at the redeveloped KCH. DHCE(KCH), HA advised that the new KCH campus would serve as a hub to provide, support and coordinate a full range of individualized psychiatric care services in collaboration with SWD, non-governmental organizations and other community partners. The ambulatory care centre within the new KCH campus would provide dynamic space for specialized clinics, day hospital, treatment and community mental health services, and facilitate support and education to families and carers.

Cost estimate of the project

45. In response to Mr POON Siu-ping's enquiry, USFH advised that the cost estimate of the project was around $8,100 million in September 2013 prices (i.e. $605 million for Phase 1 and $7,500 million for Phases 2 and 3).

Conclusion

46. In closing, the Chairman concluded that the Panel was supportive of the proposed Phase 1 redevelopment of KCH.

IV. Consultation result of the Hong Kong Code of Marketing and Quality of Formula Milk and Related Products, and Food Products for Infants and Young Children

[LC Paper Nos. CB(2)2048/13-14(05) and (06), CB(2)2080/13-14(01) and CB(2)2088/13-14(01) to (06)]

47. USFH briefed members on the results of the public consultation and the way forward for the Hong Kong Code of Marketing and Quality of Formula Milk and Related Products, and Food Products for Infants & Young Children ("the Code"), details of which were set out in the Administration's

Action

paper (LC Paper No. CB(2)2048/13-14(05)).

48. Members noted the background brief entitled "The Hong Kong Code of Marketing and Quality of Formula Milk and Related Products, and Food Products for Infants and Young Children" (LC Paper No. CB(2)2048/13-14(06)) prepared by the LegCo Secretariat.

49. Members also noted the five submissions from Hong Kong Infant and Young Child Nutrition Association; The American Chamber of Commerce in Hong Kong; Professor Gabriel LEUNG, Dean of the Li Ka Shing Faculty of Medicine of The University of Hong Kong; Hong Kong College of Community Medicine; and the Department of Paediatrics and Adolescent Medicine of The University of Hong Kong, as well as two joint submissions from 25 members of the trade and eight paediatricians of public hospitals respectively.

Scope of restrictions over promotional practices for formula milk and related products

50. Miss Alice MAK noted that while the trade generally did not object to the principle of regulating the formula milk advertisements, there were different views between the trade and the medical profession as to whether restrictions should only be applied on those products intended for infants up to six months of age. She sought information about the international practice in this regard. Dr KWOK Ka-ki held the view that the restrictions should cover formula milk for infants and young children aged 36 months or below, as promotion of follow-up formula for young children could be taken as de facto infant formula promotion through marketing practices. Dr Fernando CHEUNG expressed a similar view. Given the overwhelming promotion and advertising of formula milk with exaggerated claims on health benefits, Dr CHIANG Lai-wan considered that there was a need to impose restrictions on formula milk for infants and young children aged 36 months or below.

51. Dr Helena WONG asked whether consideration could be given to regulating only unethical marketing practices for formula milk such as false or misleading health and nutrition claims and requesting the package of these products to bear the message that breastmilk was the best food for infants, instead of imposing across-the-board restrictions on the advertising and promotion of formula milk and related products intended for infants and young children aged 36 months or below. Mr Vincent FANG suggested that as an alternative, a mechanism could be put in place by the Administration to scrutinize the trade's advertisements on formula milk for infants and young children to regulate misleading or deceptive health claims.

Action

Dr Priscilla LEUNG asked whether the Administration could standardize the health and nutrition information borne on the package of these products.

52. USFH advised that different places had imposed different restrictions on marketing of formula milk in the light of their national situation. Locally, there was formula milk that was intended for use as a sole source of nutrition for infants aged six months or below, and also for consumption by young children older than six months alongside complementary feeding. While advertising formula milk for infants below the age of six months was already not allowed currently, study had shown that the current marketing practices of promoting follow-up formula as promoting de facto infant formula through the use of packaging, branding and labelling closely resembled those of infant formula had caused confusion to mothers of newborn babies. Hence, there was a need to impose restrictions over the promotional practices for formula milk intended for infants and young children aged 36 months or below.

53. Pointing out that some parents had to choose to feed infants with formula milk for various reasons, Miss Alice MAK asked whether the restrictions would undermine these parents' right to access to information on formula milk. Dr Fernando CHEUNG considered that there should be adequate avenues to provide mothers who chose to feed their infants with formula milk with informed choices on infant feeding. Mr Vincent FANG was of the view that the restrictions would interfere free market and infringe mothers' right to access to information for making informed choices on feeding their children. Mr Albert HO considered that the Administration should conduct a social impact study to assess the impact of the restrictions on mothers in making decisions on feeding their infants and young children.

54. USFH advised that a survey of DH showed that around 60% to 70% of mothers supported the imposition of restrictions over the marketing practices of formula milk, and preferred to receive information on infant feeding which was non-commercial, accurate and not misleading. DH and many healthcare bodies had been and would continuously be providing information in this regard. In addition, the trade was allowed to provide information of their products on their websites.

55. Mr Michael TIEN relayed the trade's view that no scientific evidence was available to demonstrate that advertising formula milk for children over six months old would undermine breastfeeding. In the view of the trade, the restrictions should at the very least not be applied to formula milk for young children aged 12 months or above to follow the practices of many developed countries/places, such as New Zealand, New York and Singapore. It was noted that poor water quality was a factor leading to the underdeveloped

Action

countries' imposition of stricter restrictions over promotional practices for formula milk intended for infants and young children aged 36 months or below so as to protect breastfeeding.

56. USFH explained that the World Health Organization ("WHO") had recommended in 2013 that restrictions on marketing practices should be extended to formula milk for infants and young children up to two years of age or older. Locally, the aggressive marketing practices in promoting formula milk for infants and young children had a negative impact on parental attitudes and practices of feeding infants and young children. The Chairman remarked that notwithstanding the proposed restriction on advertising practices for formula milk for infants and young children under the age of 36 months, the trade might promote follow-up formula for young children over 36 months old as de facto infant formula promotion.

Admin

57. At the request of Mr Michael TIEN, the Administration agreed to provide after the meeting information on how the proposed restriction to be imposed upon marketing practices for formula milk for young children up to 36 months age would contribute to an increase of breastfeeding and the exclusive breastfeeding rates of Hong Kong among other countries.

Promotion of breastfeeding

58. Dr Helena WONG urged the Administration to study whether there was a significant drop in the proportion of breastfeeding for infants upon the mothers returned to work after maternity leave. If this was the case, consideration should be given to extending the maternity leave or promoting the provision of babycare facilities in the workplace in order to promote breastfeeding. Dr Fernando CHEUNG raised a similar concern. Mr Albert HO asked about the local breastfeeding rate for infants up to six months old.

59. USFH advised that the percentage of newborn babies who had been ever-breastfed was more than 80%. The percentage of babies exclusively breastfed for up to six months, however, dropped significantly to 2.3%. The rate of Hong Kong was among the lowest in the world. A factor contributing to the low breastfeeding rate in Hong Kong was the aggressive local advertising practices of formula milk.

60. Mr Vincent FANG said that members of the Liberal Party supported breastfeeding. That said, given the high rate of working mothers in Hong Kong and the lack of breastfeeding facilities in private commercial premises, it was considered not an opportune time to promote breastfeeding. USFH responded that while complementary foods could be introduced to infants

Action

over six months old, WHO recommended the continuation of breastfeeding up to 24 months and beyond.

61. Mr CHEUNG Kwok-che sought information about the work targets of the Committee on Promotion of Breastfeeding ("the Committee") set up by the Administration in April 2014 to oversee and coordinate breastfeeding promoting and supporting activities. In particular, he was concerned about whether there was a timetable to require the provision of babycare facilities in Government offices and private commercial premises.

62. USFH advised that the Committee comprised representatives from various professional healthcare bodies, academia as well as representatives of the organisations and individuals that had participated in the promotion of breastfeeding. The Committee would further strengthen the promotion, protection and support for breastfeeding through ensuring the attainment of service standards of Baby Friendly Hospital in hospitals and other healthcare facilities, promoting the provision of babycare and breastfeeding facilities in workplace and public places, and steeping up publicity and public education on breastfeeding. Dr Priscilla LEUNG opined that the Administration should produce announcements in the public interest broadcast on television and radio to provide mothers with sufficient information on the benefits of breastfeeding.

63. Mr POON Siu-ping asked how the Government would take a leading role in promoting breastfeeding and support to working mothers. USFH advised that SFH had issued an advice on public health to all Government bureaux and departments in August 2013 to encourage them to implement the breastfeeding friendly workplace policy by putting in place supportive measures which included making arrangements to meet the needs of staff in expressing breast milk during working hours; providing private space with comfortable chairs and electric outlets for breast pumps in the workplace; and providing refrigerating facilities for safe storage of breast milk. At present, more than 40 bureaux and departments had already implemented or would implement the breastfeeding friendly workplace policy.

64. Dr Priscilla LEUNG urged the Administration to include tertiary institutions and public entities in the promotion of breastfeeding friendly workplace policy. In response to Mr POON Siu-ping's enquiry about measures to be put in place to encourage private enterprises to implement the same policy, USFH advised that a working group had been set up under the Committee to provide specific recommendations to encourage private enterprises to implement the breastfeeding friendly workplace policy.

Action

[At this juncture, the Chairman informed members of his decision to extend the meeting for 15 minutes beyond its appointed time to allow more time for discussion of this item.]

Implementation of the Code

65. Expressing concern about the effectiveness of the Code which would be implemented on a voluntary basis, Dr KWOK Ka-ki called for legislation of the Code to ensure mandatory compliance. Mr CHEUNG Kwok-che and Dr Fernando CHEUNG expressed a similar view. Dr CHIANG Lai-wan urged the Administration to expeditiously implement the Code.

66. USFH advised that as a first step, the Code would be implemented on a voluntary basis. Separately, the Administration had introduced the Food and Drugs (Composition and Labelling) (Amendment) (No.2) Regulation ("Amendment Regulation") 2014 into the Legislative Council on 18 June 2014. The Amendment Regulation mandated nutritional composition requirements on infant formula, as well as nutrition labelling requirements of infant formula, follow-up formula and prepackaged food for infants and young children under the age of 36 months. As regards control on health and nutrition claims, it was observed that there was a lack of international consensus on the regulation of such claims at present. The Centre for Food Safety was currently studying the local and international situations, with a view to conducting a public consultation around end of 2014 on the regulation of health and nutrition claims on the products concerned. The Administration would map out how best to take forward the Code in the light of the latest development on the above legislative proposals.

67. There being no other business, the meeting ended at 7:19 pm.

Council Business Division 2
Legislative Council Secretariat
18 March 2015