立法會
Legislative Council

LC Paper No. CB(2)640/15-16
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 16 November 2015, at 4:30 pm
in Conference Room 3 of the Legislative Council Complex

Members present	:	Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN (Chairman) Dr Hon LEUNG Ka-lau (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 Hon CHEUNG Kwok-che Hon Albert CHAN Wai-yip Hon YIU Si-wing, BBS Hon CHAN Han-pan, JP Hon Alice MAK Mei-kuen, BBS, JP Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung Hon POON Siu-ping, BBS, MH Hon Christopher CHUNG Shu-kun, BBS, MH, JP
Members attending	:	Hon Abraham SHEK Lai-him, GBS, JP Hon Tommy CHEUNG Yu-yan, GBS, JP
Members absent	:	Dr Hon Helena WONG Pik-wan Dr Hon Elizabeth QUAT, JP
Public Officers attending	:	Items IV to VI Dr KO Wing-man, BBS, JP Secretary for Food and Health

Mr Richard YUEN Ming-fai, JP
Permanent Secretary for Food and Health (Health)

Item IV

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

Mr FONG Ngai
Principal Assistant Secretary for Food and Health (Health) 3
Food and Health Bureau

Miss Maggie CHOW Wan-kam
Head, Boards and Councils (Boards and Council Office)
Department of Health

Mr Joseph SIU Wing-ho
Deputy Secretary (Medical Council) 1
Department of Health

Item V

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

Ms Clara CHIN
Director (Finance)
Hospital Authority

Dr K M CHOY
Chief Manager (Service Transformation)
Hospital Authority

Item VI

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

Clerk in attendance	:	Ms Maisie LAM Chief Council Secretary (2) 5
Staff in attendance	:	Item IV Ms Wendy KAN Assistant Legal Adviser 6 All items Ms Janet SHUM Senior Council Secretary (2) 5 Ms Priscilla LAU Council Secretary (2) 5 Miss Sandra SIU Legislative Assistant (2) 5 Ms Louisa YU Clerical Assistant (2) 5

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I. Confirmation of minutes of previous meeting
[LC Paper No. CB(2)195/15-16]

The minutes of the meeting held on 15 October 2015 were confirmed.

II. Information paper(s) issued since the last meeting
[LC Paper Nos. CB(2)70/15-16(01), CB(2)71/15-16(01), CB(2)74/15-16(01), CB(2)97/15-16(01), CB(2)117/15-16(01), CB(2)176/15-16(01) and CB(2)266/15-16(01)]

2. Members noted the following papers issued since the last meeting -

(a) Letter dated 16 October 2015 from the Administration enclosing the Hong Kong Guide to Good Manufacturing Practice for the secondary packaging of pharmaceutical products and the relevant parts of the Guide to Good Manufacturing Practice for Medicinal Products published by the Pharmaceutical Inspection Co-operation Scheme;

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(b) Letter dated 16 October 2015 from Dr KWOK Ka-ki suggesting the Panel to discuss issues relating to the healthcare referral mechanism between the Department of Health ("DH") and the Hospital Authority ("HA");

(c) Letter dated 19 October 2015 from Dr KWOK Ka-ki suggesting the Panel to discuss the implications of the findings of the 2013 Pay Level Survey for the civil service on HA;

(d) Information paper provided by the Administration entitled "Action plan for the implementation of the recommendations of the Steering Committee on Review of Hospital Authority";

(e) Letter dated 20 October 2015 from Dr Elizabeth QUAT suggesting the Panel to discuss issues relating to women's health;

(f) Letter dated 29 October 2015 from Dr Elizabeth QUAT suggesting the Panel to discuss issues relating to organ donation; and

(g) Joint letter dated 11 November 2015 from Miss Alice MAK and Mr KWOK Wai-keung suggesting the Panel to discuss issues relating to regulation of electronic cigarettes.

III. Items for discussion at the next meeting

[LC Paper Nos. CB(2)235/15-16(01) and (02)]

3. Members agreed to discuss the following items at the next regular meeting scheduled for 21 December 2015 at 4:30 pm -

(a) Proposed creation of two supernumerary directorate posts in DH for the review of regulation of private healthcare facilities;

(b) Hospital Authority's private patient services; and

(c) Patient safety management in Hospital Authority.

IV. Proposed Member's Bill to amend the Medical Registration Ordinance (Cap. 161)

[LC Paper Nos. CB(2)235/15-16(03) to (05)]

4. Mr Tommy CHEUNG briefed members on his proposed Member's Bill to amend the Medical Registration Ordinance ("the Ordinance") to

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increase the number of lay members of the Medical Council of Hong Kong ("MCHK") and that of the Preliminary Investigation Committee ("PIC") and the Health Committee ("the legislative proposal"), details of which were set out in his briefing notes (LC Paper No. CB(2)235/15-16(03)).

5. At the invitation of the Chairman, Secretary for Food and Health ("SFH") responded that the strategic review being conducted by the Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development ("the Steering Committee") covered, among others, the composition (including lay membership) as well as the complaint handling and disciplinary inquiry mechanisms of the statutory regulatory bodies of the 13 healthcare professions subject to statutory regulation (including the medical profession). It was noted that there was a global trend for greater involvement of lay members in regulatory bodies. The Administration also agreed that there was room to improve the mechanism for complaints investigation and disciplinary inquiry, including increasing lay involvement in the composition as well as complaints handling and disciplinary inquiry mechanism of MCHK, further enhancing the transparency and efficiency of the mechanism and strengthening the mechanism for avoiding conflict of interest. It would be more appropriate to cover the legislative proposal under the strategic review which would be completed in the first half of 2016. As regards Mr Tommy CHEUNG's concern about facilitating more non-locally trained medical graduates to practise in Hong Kong, it should be noted that the number of candidates passing Part III Clinical Examination of the Licensing Examination had increased from 21 (or 29%) in 2010 to 74 (or 48%) in 2014 following the measures implemented by MCHK as set out in paragraph 6 of the Administration's paper (LC Paper No. CB(2)235/15-16(04)).

6. Dr LEUNG Ka-lau asked whether the Panel had to form a position on the legislative proposal following discussion. The Chairman replied in the negative, adding that the discussion served the purpose for Mr Tommy CHEUNG to consult the Panel on the legislative proposal. Members could seek the response of Mr Tommy CHEUNG and/or the Administration to their enquiries. Subject to the discussion, Mr Tommy CHEUNG could then proceed to seek the President's opinion in writing on whether the legislative proposal related to public expenditure; political structure; or the operation of the Government that it could not be introduced, or Government policies that required the written consent of the Chief Executive ("CE").

7. Members noted the paper entitled "Regulation of medical profession" provided by the Administration, and the information note entitled "Composition of the Medical Council of Hong Kong and its Preliminary

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Investigation Committee and Health Committee" prepared by the Legislative Council ("LegCo") Secretariat (LC Paper No. CB(2)235/15-16(05)).

The legislative proposal

8. Mr Vincent FANG said that the Liberal Party welcomed the legislative proposal. He added that increasing the number of lay members in MCHK was among the various proposals jointly put forward by the Liberal Party and the Democratic Party to the Administration in February 2014. He was concerned about whether medical practitioners working in the public sector were currently adequately represented in MCHK. According to the Ordinance, among the 24 medical practitioner members in MCHK, seven were elected by registered medical practitioners, seven others were nominated by the Hong Kong Medical Association ("HKMA") from among its members, and two each were nominated by the Director of Health ("DoH"), the University of Hong Kong ("HKU"), the Chinese University of Hong Kong ("CUHK"), HA and the Hong Kong Academy of Medicine ("HKAM") and appointed by CE.

9. SFH advised that there was no cause for the concern, as medical practitioners from the public sector could stand for the respective elections by registered medical practitioners and by HKMA for nomination for the offices of MCHK. In addition, the two medical practitioners nominated by HKAM could be from the public or private sector.

10. Dr KWOK Ka-ki opined that the proposal to increase the number of lay members, who would be appointed by CE, in MCHK from four to eight went against the principle of professional autonomy conferred upon the profession by Article 142 of the Basic Law. SFH stressed that MCHK was an independent statutory body operated under the principle of professional autonomy, as its medical practitioner members outnumbered its lay members (i.e. 24 members versus four members). According to the legislative proposal, the number of medical practitioner members and lay members in MCHK would be 24 and 8 respectively.

11. Dr LEUNG Ka-lau said that to his understanding, the medical sector generally raised no objection to increasing the number of lay members to be appointed by CE in MCHK. However, there was a need to maintain the ratio of appointed members to elected members in MCHK in the last legislative exercise in 1997. Hence, the total number of MCHK members being elected by registered medical practitioners and nominated by HKMA should in parallel be increased by four having regard to the fact that the number of registered medical practitioners had increased significantly over the years. As a further step, taking into account that the ratio of lay members to medical practitioner members in MCHK would be change from 1:6 (i.e. four

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lay members to 24 medical practitioner members) to 1:3 (i.e. eight lay members to 24 medical practitioner members) under the legislative proposal, consideration could be given to respectively increasing the number of lay members and medical practitioner members to 10 and 30 to achieve the ratio of 1:3.

12. Expressing support for the legislative proposal which, in his view, could help shorten the unduly long time taken by MCHK for handling complaints, Dr Fernando CHEUNG agreed that the number of medical practitioner members in MCHK should be greater than the number of members appointed by CE. He opined that lay members of MCHK should include, among others, patient representatives. Mr Albert CHAN said that the People Power welcomed any proposal to increase public engagement. He, however, expressed concern that under the current term Government, any increase in the number of members appointed by CE in the statutory regulatory bodies might result in increased Government control. Mr Tommy CHEUNG did not consider that this should be an issue of concern. As reference, the ratio of professional members to lay members was 3:1 in the Dental Council, 2:1 in the Veterinary Surgeons Board, and 1:1 in both the Pharmacy and Poisons Board and the Chiropractors Council.

13. Dr LEUNG Ka-lau remarked that the number of lay members in MCHK had no relevance to the requirement that non-locally trained medical graduates had to take the Licensing Examination in order to practise in Hong Kong which was put forth by Mr Tommy CHEUNG as a justification for the legislative proposal, as the latter was governed by other provisions of the Ordinance. Mr WONG Ting-kwong said that the Democratic Alliance for the Betterment and Progress of Hong Kong was open-mind on the legislative proposal. He, however, held the view that addressing the current medical manpower shortage and increasing lay involvement in the composition and complaint handling mechanism of MCHK in response to community calls so as to increase public confidence in, and the transparency of, its operation were two different issues. For the former, there was a need to strike a balance between ensuring that those who wished to register as medical practitioners in Hong Kong after having received medical training elsewhere had attained a professional standard comparable to that of local medical graduates and facilitating more non-locally trained medical graduates to practise in Hong Kong. Mr Albert CHAN opined that more measures should be taken to facilitate more non-locally trained medical graduates to practise in Hong Kong.

14. Mr Tommy CHEUNG stressed that the primary objectives of the legislative proposal were to take heed of calls from different sectors of the community for increasing lay involvement in MCHK to ensure that the decisions made would be in line with public interest, and to shorten the time

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required by MCHK for handling complaints against registered medical practitioners and conducting preliminary investigations into prima facie cases of professional misconduct. In terms of the latter, the existing quorum of a meeting of PIC of MCHK had to include at least one lay member. It was difficult to ascertain at this stage whether the legislative proposal, as a first step to reform the composition and complaints handling mechanism of MCHK in the 2015-2016 legislative session, would help to achieve other outcomes in the longer term. Apart from looking forward to the proposals from the Administration on healthcare professional development after the Steering Committee completed its strategic review in the first half of 2016, he had, on another occasion, called on CE to feature in his 2016 Policy Address an initiative to comprehensively reform MCHK to address public concern in this regard.

15. Miss Alice MAK asked whether more than one lay member should be added to the composition of PIC so as to achieve the objective of shortening the time for MCHK to process complaints. Dr LEUNG Ka-lau sought elaboration from the Administration about the complaint handling process of MCHK. He was concerned about how Mr Tommy CHEUNG's proposal of increasing the number of lay members in PIC from one to two could expedite the complaint handling process, as more time might be required if each complaint had to be considered by two lay members of PIC during the initial consideration stage.

16. Deputy Secretary (Medical Council)1, DH advised that according to the Medical Practitioners (Registration and Disciplinary Procedure) Regulation (Cap. 161E), upon receipt of a complaint, the PIC chairman (or in his absence, the PIC deputy chairman) would consider it and consult the PIC deputy chairman (or the PIC chairman) to decide whether the complaint was groundless or frivolous, and should not proceed further or that it should be referred to PIC for full consideration. Under the existing arrangement, if both the PIC chairman and the PIC deputy chairman considered that the complaint could not or should not proceed further, they had to seek the agreement of a lay member of PIC before dismissing the complaint. Mr Tommy CHEUNG advised that to his understanding, the four lay members of MCHK currently took turn to perform their roles in the pre-preliminary investigations every three months. It was expected that with the increase of lay members in MCHK from four to eight and the increase of lay members in PIC from one to two, two teams, each with one lay member of PIC forming its membership, could work in parallel to consider the complaints. He added that the Working Group on the Reform of the Medical Council set up by MCHK in 2001 had recommended, among others, increasing the number of lay members in PIC from one to three.

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17. Mr Vincent FANG asked why the Administration had not taken forward the reform proposals submitted by the Working Group on the Reform of the Medical Council. SFH said that he was not in a position to explain the decision made by the previous term Government. He, however, noted that the previous term Government had devoted much effort to take forward the healthcare reform at that time.

18. Miss Alice MAK expressed dissatisfaction that the Administration could have been more proactive in reforming the complaint handling mechanism of MCHK, as demonstrated by the fact that the discussion time of the subject by the Panel as proposed by the Administration had been deferred from the first half of 2015 to the second half of 2015, and further deferred to the first half of 2016. SFH assured members that the Administration would take forward the relevant recommendations of the Steering Committee as appropriate upon the completion of the strategic review in the first half of 2016.

Secretarial support for MCHK

19. Referring to the arrangements for the accountant and legal professions, Dr KWOK Ka-ki was of the view that the secretariat support for MCHK in discharging its functions should rest with the profession instead of the Government to preserve the principle of profession autonomy.

20. SFH advised that there was no conflict between upholding the principle of professional autonomy and providing secretarial support for MCHK. It should be noted that the medical profession was different from professional self-regulatory bodies outside the health remit which were generally financially independent from the Government. At present, the Government used public money to provide secretariat service (including legal advice) through DH to support MCHK. It should be noted that the registration fee collected by MCHK was far from adequate to cover the operation cost involved in this regard. In addition, there were views in the community that the Administration should play a role in the operation of MCHK to ensure the quality of healthcare. Dr KWOK Ka-ki considered that there might not be strong views from members of the public in this regard. In addition, it was expected that the registered medical practitioners would be willing to shoulder the cost of operating a secretariat independent from the Government. Dr LEUNG Ka-lau expressed a similar view. Dr KWOK Ka-ki asked whether the Steering Committee would examine this issue. SFH advised that the strategic review of the Steering Committee covered, among others, a broad spectrum of issues relating to the existing regulatory framework of the 13 healthcare professions concerned.

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21. Citing cases whereby it took more than six to 12 months for the secretariat of MCHK to exchange correspondence with the complainant and process the documents and statutory declarations as examples, Miss Alice MAK expressed concern about the cumbersome administrative procedures of MCHK in handling complaints. She urged the Administration to review the operation of the secretariat of MCHK. Referring to the judgment of a judicial review case heard by the High Court of First Instance handed down in October 2015, in which the Judge expressed concern about MCHK's protracted and cumbersome process and procedures for handling complaints, the reliance on medical practitioners and lay persons to handle the complaints on a voluntary and part-time basis, inadequate administrative support and personnel to handle the volume of complaints, and the lack of appropriate guidelines, discipline and structure in handling complaints, Dr Fernando CHEUNG asked whether any immediate actions could be taken by the Administration to enhance efficiency of the secretariat of MCHK in handling complaints. Noting that the mechanism of declaration of interest was an issue of concern to the Judge of the above case, Mr Tommy CHEUNG asked about the guidelines put in place by MCHK in this regard.

22. SFH advised that it was incumbent upon the secretariat of MCHK to handle each complaint with due care as an investigation of any complaint might end up in inquiry of MCHK. While the Administration would review the manpower and resource requirements of the secretariat of MCHK, there was a need to ensure proper use of public funding. It should also be noted that the workload of the medical practitioner members involved in the handling of complaints was heavy. In the Administration's view, lay involvement and avoidance of conflict of interests were important elements of the complaint handling mechanism of MCHK.

V. Proposed $10 billion endowment fund to the Hospital Authority for public-private partnership initiatives

[LC Paper Nos. CB(2)235/15-16(06) and (07)]

23. Members noted the paper provided by the Administration (LC Paper No. CB(2)235/15-16(06)) and the information note prepared by the LegCo Secretariat (LC Paper No. CB(2)235/15-16(07)) on the subject under discussion.

24. The Chairman reminded members that in accordance with Rule 83A of the Rules of Procedures, they should disclose the nature of any direct or indirect pecuniary interests relating to the funding proposal before they spoke on the subject.

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[Note: 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.]

Use of the $10 billion

25. While supporting the provision of funding for enhancing support to patients of HA, Mr Albert CHAN was concerned about the scope of usage of the $10 billion proposed to be allocated to HA for setting up an endowment fund to support its clinical public-private partnership ("PPP") initiatives ("the HA PPP Fund"). Dr KWOK Ka-ki said that there was no reason for not supporting the proposal. He, however, expressed dissatisfaction that HA could only make use of the investment returns to be generated from the endowment fund to fund its PPP initiatives. In his view, HA should be allowed to use the seed capital not only for funding its PPP initiatives, but also for introducing more target therapy drugs for treating cancers in the HA Drug Formulary and recruiting more retired doctors to work on a part-time basis in order to address its medical manpower constraint problem. Dr Fernando CHEUNG expressed support for any initiatives that aimed at shortening patients' waiting time for clinical services. Pointing out that about 70% of the outpatient consultations were currently provided by the private sector, he sought elaboration about how the channelling of some patients of HA to the private sector through funding the relevant PPP initiatives by the investment returns generated by the HA PPP Fund could help to address the imbalance between public and private healthcare services as put forth in the Administration's paper.

26. SFH advised that the general principle was that the operation of the HA PPP Fund would be funded by investment returns. That said, the seed capital might also be used in response to special needs that might arise. Under the proposal, the investment returns from the HA PPP Fund would be used by HA for regularizing and enhancing PPP initiatives undertaken on a pilot basis, as well as developing new PPP initiatives in future. Referring to Dr KWOK Ka-ki's concern about the scope of the HA Drug Formulary and the manpower constraint of HA, SFH advised that a one-off grant of $10 billion and a time-limited funding of $570 million had been respectively allocated to the safety net of the Samaritan Fund in 2012 to support the continued operation of the Samaritan Fund and to give more headroom for HA to increase the types of subsidized drugs, and to HA in the period of 2015-2016 to 2017-2018 for re-employing suitable retirees of those grades and disciplines which were facing severe staff shortage problem.

27. SFH further advised that at present, a large proportion of stable chronic disease patients were under the care of the public healthcare system. HA could make use of PPP to tap the available capacity and capability of the

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private sector in managing more patients with chronic diseases. A case in point was the existing General Outpatient Clinic Public-Private Partnership Programme ("GOPC PPP") which helped to enable a portion of HA's patients with hypertension (with or without hyperlipidaemia) and diabetes mellitus to have better means to access private healthcare services so as to alleviate pressure on the public general outpatient services. Director (Cluster Services), HA ("D(CS), HA") supplemented that the outpatient services provided by the private sector currently mainly took care of patients' episodic illness. It was hoped that PPP could help to promote chronic disease management in the community with greater participation from private doctors.

28. Noting that HA planned to launch a Colonoscopy PPP Programme dovetailing with the Government's Colorectal Cancer Screening Pilot Programme, Dr LEUNG Ka-lau declared that he was a privately practised specialist in colorectal surgery. Holding the view that HA had a conflicting role of being both the provider and the purchaser of services, he opined that the Administration should not allocate the $10 billion to HA but should set up a fund management committee under the Food and Health Bureau to make use of the investment returns of the $10 billion to procure services provided either by HA or the private healthcare sector in order to clear the waiting list for the relevant services of HA.

29. SFH stressed that the main objectives of the HA PPP Fund was to ease the existing bottleneck in, and shorten the waiting time for, certain services of HA. Hence, there was a need for the Administration to work with HA to identify and develop the PPP initiatives. In addition, HA was in a better position than the Administration, in terms of the expertise involved, to monitor the quality of the clinical services provided by the private sector under the PPP initiatives. HA would also monitor the progress of individual participating patients through the future Electronic Health Record Sharing System ("eHRSS"). This apart, patients who chose to withdraw from the PPP programmes could revert to HA's general outpatient clinics ("GOPCs") for follow-up.

Financial arrangement for the endowment fund

30. Noting that the $10 billion endowment fund would be placed with the Exchange Fund ("the Placement"), Dr KWOK Ka-ki expressed concern that the actual annual investment return on the Placement could fluctuate from year to year. There might be cases that the annual rate of return would be less than 4.3% as assumed by the Administration for the purpose of financial planning. Mr Albert CHAN raised a similar concern having regard to the substantial investment loss of more than $60 billion recorded in foreign exchange in the third quarter of 2015. He suggested that $5 billion out of the

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$10 billion should be used by HA to set up a loan scheme for its staff such that HA could use the interest generated to fund its various initiatives. Mr POON Siu-ping expressed concern that the estimated investment return of around $430 million per annum would barely meet the annual total expenditure for the PPP initiatives by 2020-2021 which was estimated by the Administration to reach around $420 million. Mr YIU Siu-wing was concerned that the expansion of the existing PPP programmes and the implementation of the new PPP initiatives would be affected if the annual investment return on the Placement was lower than expected. Given that the estimated annual total expenditure for the PPP programmes and initiatives would be lower than the annual investment return on the Placement in the early years of the implementation, he sought information about the use of the surplus, if any, recorded under the HA PPP Fund.

31. SFH explained that the reason why it was estimated that the annual total expenditure for the PPP programmes and initiatives would increase from around $240 million in 2016-2017 to around $420 million in 2020-2021 was due to the fact that the enhancements to the existing PPP programmes and the new PPP initiatives would be implemented step by step. It was expected that the $430 estimated annual investment return available from the Placement, as well as the surplus carried over from previous financial years (if any) would be adequate to finance the continued operation of existing PPP programmes as well as the implementation of the new initiatives as set out in paragraphs 19 to 21 of the Administration's paper and other initiatives to be developed in the near future. As advised at the earlier part of the meeting, the seed capital might also be used in response to special needs that might arise.

32. Dr Fernando CHEUNG asked whether consideration could be given to collaborating with non-governmental organizations in exploring new PPP initiatives to meet the healthcare needs of patients suffering from common mental disorder and dementia, or required of infirmary care services. He was particularly concerned that there were cases whereby children with special education needs (such as hyperactivity disorder) had to wait for four years for first consultation. SFH said that the Administration was open-minded on suggestions on developing various new PPP initiatives.

Monitoring of the PPP initiatives

33. Dr LEUNG Ka-lau held the view that it was justifiable to use public money to fund PPP initiatives only when the service capacity and efficiency could be enhanced with less cost. To assess the effectiveness of the various PPP initiatives introduced by HA, he considered that HA should in the future make public information on the respective average cost incurred by HA and under the relevant PPP initiatives for providing the same service, and the

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average additional waiting time required of patients for HA's service without the introduction of the relevant PPP initiatives. As a case for reference, he requested HA to provide after the meeting information in this regard for the existing Pilot Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector.

34. D(CS), HA advised that the factor of cost effectiveness was only one of the many factors HA would take into consideration in determining whether a PPP programme should be introduced or continued. For instance, promoting primary care to facilitate better disease prevention and redressing the imbalance between public and private healthcare services on managing chronic diseases were considerations taken into account by HA in rolling out GOPC PPP. He agreed to provide relevant information requested by Dr LEUNG Ka-lau after the meeting.

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35. Mr Albert CHAN called on the Administration to ensure transparency on the use of the investment returns and monitor whether there were any cases of over-charge or misuse by the private doctors participating in the various PPP initiatives. SFH advised that there was no cause for concern about the charges of participating private doctors as the fee and co-payment, if any, to be paid by patients for each consultation would be fixed. In addition, participating private doctors were required to enter into eHRSS the relevant clinical information in the patients' records after each consultation.

36. Dr LEUNG Ka-lau relayed the views of some private doctors that under certain PPP programmes of HA, the fee paid by HA to the participating private doctors was too low to cover the cost involved. In some cases, some form of co-payment from patients was required and this might deter patients from participating in the programmes. He was of the view that the service fee for participating private doctors should be on par with the average cost of HA for providing the service, and the service fee setting mechanism of HA should be made more transparent.

37. D(CS), HA advised that while the relevant service cost of HA could serve as a reference, HA would give due regard to the findings of its market research and discuss with the private sector in setting the service fee for participating private doctors and where appropriate, the co-payment required of patients under the various PPP initiatives. The participation rate of private doctors and patients would help HA to assess whether the level of the service fee and co-payment was reasonable. For those patients who chose to withdraw from the PPP programmes, HA would solicit information on their reasons for withdrawal.

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GOPC PPP

38. Mr POON Siu-ping asked about the participation rate of private doctors in, and feedback of patients towards GOPC PPP launched in Kwun Tong, Wong Tai Sin and Tuen Mun districts in July 2014. D(CS), HA advised that it was originally estimated that about 60 private doctors in the three districts would enrol in GOPC PPP. Hence, it was considered satisfactory that as at end October 2015, a total of 91 private doctors, which represented a significant proportion of the private doctors in the three districts, had enrolled in GOPC PPP. The enrolment process was ongoing and interested private doctors in these districts were welcomed to enrol in GOPC PPP at any time. In the meantime, HA was conducting an interim review to look into the Programme's scope, operations and support. As announced by CE in the 2015 Policy Address, HA would extend GOPC PPP to the remaining 15 districts in phases. Considering the responses from private doctors and patients as well as results from the interim review, it was expected that the scope of chronic diseases and medications under GOPC PPP might be expanded where appropriate. In addition, modification would be made to the information technology platform for the enrolled private doctors to access the electronic health records of the participating patients.

39. Dr KWOK Ka-ki considered the respective enrolment of 1 618 and 3 647 patients in the Tin Shui Wai Primary Care Partnership Project ("TSW PPP") and GOPC PPP as of 31 March 2015 unsatisfactory. He requested HA to provide statistics to explain how the implementation of GOPC PPP could help shortening the waiting time for HA's general outpatient services.

40. D(CS), HA advised that TSW PPP was launched in 2008 to test the use of PPP model. HA had stopped inviting patients and private doctors to join TSW PPP in recent years as it would subsequently be subsumed into GOPC PPP to be launched in the Yuen Long district. As regards GOPC PPP, a total of 6 028 patients had enrolled as at end of October 2015. The number of participating patients had already exceeded the initial target (i.e. 6 000 patients) for the entire two-year pilot and was expected to reach around 8 000. Given that each participating patient was entitled to receive up to 10 subsidized consultations each year and assuming that the number of participating patients for each district would be around 2 000 upon the extension of GOPC PPP to the remaining 15 districts, it was expected that more than two hundred thousands attendances would be channelled to the private sector per annum. This would provide some relief to HA's general outpatient services on the one hand, and on the other hand promote chronic disease management in the community with greater participation from private doctors. HA could provide details of the above statistics after the meeting.

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Conclusion

41. In closing, the Chairman concluded that the Panel raised no objection to the Administration's submission of the financial proposal to the Finance Committee ("FC") for consideration.

VI. Update on the implementation of the Elderly Health Care Voucher Scheme

[LC Paper Nos. CB(2)235/15-16(08) and (09)]

42. Members noted the paper provided by the Administration (LC Paper No. CB(2)235/15-16(08)) and the background brief prepared by the LegCo Secretariat (LC Paper No. CB(2)235/15-16(09)) on the subject under discussion.

43. The Chairman reminded members that in accordance with Rule 83A of the Rules of Procedures, they should disclose the nature of any direct or indirect pecuniary interests relating to this funding proposal before they spoke on the subject.

Scope of the Elderly Health Care Voucher Scheme and voucher amount

44. While expressing support for providing a supplementary provision of $380.7 million to meet the estimated expenditure for the Elderly Health Care Voucher ("EHV") Scheme in 2015-2016, Miss Alice MAK called on the Administration to lower the eligible age for the EHV Scheme from 70 to 65, if not to 60, years old. Mr POON Siu-ping expressed a similar view and suggested that, in lowering the eligible age for the EHV Scheme, the Administration could impose means test on, or lower the annual voucher amount for, those elders under the age of 70. Miss Alice MAK urged the Administration to provide separate dental care vouchers to facilitate elders to make use of the dental care services in the private sector, as the limited scope of public dental care services was far from adequate to meet the dental care needs of the elderly. The Chairman suggested that the financial cap on the cumulative amount of EHV in the account of the eligible elders should be revised upward, for example, from $4,000 to $8,000, so as to encourage more elders to make use of the EHV for dental care services. SFH responded that the Administration noted members' various suggestions to further enhance the EHV Scheme.

Pilot scheme at the University of Hong Kong – Shenzhen Hospital

45. Noting that the Administration had launched a pilot scheme in October 2015 to allow eligible Hong Kong elders to use their EHV to meet the fees

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for outpatient services provided by the University of Hong Kong – Shenzhen Hospital ("HKU-SZ Hospital"), Miss Alice MAK urged the Administration to expand the pilot scheme to cover hospitals and clinics in other cities on the Mainland. Dr KWOK Ka-ki remarked that HKU-SZ Hospital was not located in the vicinity of the areas where most of the Hong Kong elders on the Mainland resided, such as Dongguan. Dr LEUNG Ka-lau said that while he did not object to expanding the scope of the EHV Scheme to enable eligible elders who resided regularly on the Mainland to use their EHV to meet their expenses for private outpatient services on the Mainland, the Administration should consult the Panel before its launching of the pilot scheme. He opined that the pilot scheme was contrary to the objective of the EHV Scheme of enabling eligible elders to use private primary care services, as HKU-SZ Hospital was a tertiary hospital providing specialist services. In his view, the pilot scheme should cover healthcare service providers which were more easily accessible by the Hong Kong elders residing on the Mainland, in particular those service providers located in the whole Guangdong Province.

46. SFH explained that the issues to be considered in expanding the scope of the EHV Scheme to allow eligible Hong Kong elders to make use of EHV on the Mainland included, among others, whether the healthcare service providers concerned would accept the use of EHV, their accessibility to the eHealth System and exchange rate of Renminbi against Hong Kong Dollars. It should also be noted that management of acute episodic conditions was mainly provided by hospitals on the Mainland. In response to calls from the community and members, as a first step, the pilot scheme was launched at HKU-SZ Hospital which had a clinical governance structure similar to that of Hong Kong. The outpatient services covered under the pilot scheme included, among others, family medicine and dental care. The Chairman remarked that while the Administration had not consulted the Panel on the pilot scheme, the issue had been discussed at the Policy briefing cum meetings of the Panel. The Chairman suggested and members agreed that the Administration should revert to the Panel on the implementation of the EHV Scheme, including the pilot scheme, at a future meeting.

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47. Dr KWOK Ka-ki expressed concern about the financial arrangement between the Shenzhen Municipal Government and HKU on the reimbursement provided to HKU-SZ Hospital under the EHV Scheme. SFH advised that he could not provide the information requested by Dr KWOK Ka-ki which was outside the purview of the pilot scheme.

Monitoring of voucher claims

48. Noting that 121 anomalous cases involving 2 167 claims had been identified by DH in the course of checking the claim transactions under the

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EHV Scheme since its launch in 2009, Mr POON Siu-ping asked whether information of the healthcare service providers concerned would be made public.

49. Assistant Director of Health (Family and Elderly Health Services) advised that the monitoring mechanisms currently put in place by DH included routine checking, monitoring and investigation of aberrant patterns of transactions and, where necessary, investigation of complaints. The checking of claim transactions by DH had so far covered 90% of the enrolled healthcare service providers with claims made. As for the 121 anomalous cases which were found mostly related to errors in procedures or documentation, the healthcare service providers would be required to return the voucher amount reimbursed if they could not prove the provision of the relevant healthcare services. Any cases suspected of fraud or provision of false information etc. would also be referred to the Police for investigation.

Effectiveness of the EHV Scheme

50. Noting that many of the claim transactions made under the EHV Scheme were for the management of acute episodic conditions and follow-up of chronic diseases, Dr Fernando CHEUNG queried how the objectives of promoting primary care and the family doctor concept could be achieved under the EHV Scheme. In his view, public monies should better be used for improving the service capacity of the Elderly Health Centres and increasing the consultation quotas of the public GOPCs.

51. SFH advised that the main objective of the EHV Scheme was to enable eligible elders to use private primary care services at their choice. It should be noted that DH and HA had been implementing various projects and initiatives seeking to enhance primary care in Hong Kong. Dr LEUNG Ka-lau remarked that it was a good sign to observe the growing number of eligible elders using EHV following the increase in the annual voucher amount from $1,000 to $2,000 in June 2014.

52. Mr POON Siu-ping and Dr Fernando CHEUNG enquired about when DH would complete its comprehensive review of the EHV Scheme. SFH advised that a definite timetable was not available yet.

Conclusion

53. In closing, the Chairman concluded that the Panel raised no objection to the Administration's submission of the financial proposal to FC for consideration.

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VII. Any other business

54. There being no other business, the meeting ended at 6:45 pm.

Council Business Division 2
Legislative Council Secretariat
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