立法會
Legislative Council

LC Paper No. CB(2)2084/15-16
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 18 April 2016, 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 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 Dr Hon Helena WONG Pik-wan Dr Hon Elizabeth QUAT, JP Hon POON Siu-ping, BBS, MH
Member attending	**:**	Hon Charles Peter MOK, JP
Members absent	**:**	Hon Vincent FANG Kang, SBS, JP Hon Christopher CHUNG Shu-kun, BBS, MH, JP

Public Officers attending : Item III

Mr Sidney CHAN, JP
Commissioner for the Electronic Health Record
Food and Health Bureau

Ms Ida LEE
Deputy Head (eHealth Record), Electronic Health Record Office
Food and Health Bureau

Dr N T CHEUNG
Consultant (eHealth), Electronic Health Record Office
Food and Health Bureau

Items IV to VI

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

Item IV

Ms Wendy AU Wan-sze
Deputy Secretary for Food & Health (Health) 2 (Acting) / Principal Assistant Secretary for Food & Health (Health) Special Duties 1

Dr Edmond MA Siu-keung
Consultant (Research Office)
Food and Health Bureau

Ms Angel FAN On-ki
Chief Secretariat Executive (Grant Management)
Food and Health Bureau

Dr Richard COLLINS
Scientific Review Director
Food and Health Bureau

Item V

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

Dr Cindy LAI Kit-lim, JP
Deputy Director of Health

Dr Amy CHIU Pui-yin, JP
Assistant Director of Health

Item VI

Ms Wendy AU Wan-sze
Deputy Secretary for Food & Health (Health) 2 (Acting) / Principal Assistant Secretary for Food & Health (Health) Special Duties 1

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

Ms TONG Yuen-fan
Organ Donation Coordinator
Hospital Authority

Dr Anne FUNG Yu-kei
Assistant Director 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 Louisa YU
Legislative Assistant (2) 5

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

[LC Paper Nos. CB(2)1181/15-16(01), CB(2)1181/15-16(02) and CB(2)1259/15-16(01)]

Members noted the following papers issued since the last meeting:

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(a) Letters dated 24 March 2016 from Dr Elizabeth QUAT and Dr KWOK Ka-ki expressing concerns on the adequacy of supply of vaccines for local residents; and

(b) Administration's response to the above two letters from Dr Elizabeth QUAT and Dr KWOK Ka-ki.

II. Items for discussion at the next meeting

[LC Paper Nos. CB(2)1269/15-16(01) and (02)]

2. Members agreed to discuss the following items at the next regular meeting scheduled for 16 May 2016 at 4:30 pm:

(a) Voluntary accredited registers scheme for healthcare personnel who are currently not subject to statutory regulation; and

(b) Policy on rare diseases and drug for rare diseases.

(*Post-meeting note:* On the instruction of the Chairman, the item "Colorectal Cancer Screening Pilot Programme" has been included in the agenda of the above meeting. Separately, at the request of the Administration and with the concurrence of the Chairman, discussion of item (b) above has been deferred to a future meeting.)

III. Operation of the Public-Private Interface - Electronic Patient Record Sharing Pilot Project and the Electronic Health Record Sharing System

[LC Paper Nos. CB(2)1094/15-16(01), CB(2)1269/15-16(03) and (04), CB(2)1320/15-16(01) and CB(2)1329/15-16(01)]

3. Commissioner for the Electronic Health Record ("eHRC") briefed members on the operation of the Public-Private Interface - Electronic Patient Record Sharing ("PPI-ePR") Pilot Project and the Electronic Health Record Sharing System ("eHRSS"), details of which were set out in the Administration's paper (LC Paper No. CB(2)1269/15-16(03)).

4. Members noted the background brief entitled "Operation of the Public-Private Interface - Electronic Patient Record Sharing Pilot Project and the Electronic Health Record Sharing System" prepared by the Legislative Council ("LegCo") Secretariat (LC Paper No. CB(2)1269/15-16(04)).

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5. Members noted the submission from the Hong Kong Medical Association ("the Medical Association") (LC Paper No. CB(2)1320/15-16(01)); and the Administration's supplementary paper attaching its letter dated 15 April 2016 to the Medical Association concerning the subject under discussion which was tabled at the meeting (LC Paper No. CB(2)1329/15-16(01)).

Transitional arrangement from PPI-ePR to eHRSS

6. Mr Charles MOK enquired about the participation of healthcare providers ("HCPs") and healthcare recipients ("HCRs") in eHRSS since its launch on 13 March 2016. He was concerned about whether the Administration had set any target for increasing the number of registration of HCPs and HCRs.

7. eHRC advised that as of 15 April 2016, around 55 000 HCRs had registered to join eHRSS. As a reference for rough comparison, it was not until the fourth year since the PPI-ePR Pilot Project commenced operation that it managed to enrol more than 50 000 patients. As for HCPs, in addition to the 11 private hospitals, 120 out of the 300-odd HCPs which had submitted applications to join eHRSS had completed registration. These HCPs had opened user accounts for about 1 000 healthcare professionals. As a reference, there were at present about 3 500 private healthcare professionals enrolled in the PPI-ePR Pilot Project. The Administration expected that more and more patients and HCPs would take part in the new two-way sharing arrangement under eHRSS which would bring more benefits to both patients and HCPs than the one-way sharing arrangement under the PPI-ePR Pilot Project. Dr LEUNG Ka-lau remarked that the number of healthcare staff engaged by those healthcare professionals participated in the PPI-ePR Pilot Project might reach more than 10 000. In response to Mr POON Siu-ping's enquiry about the number of participants of the PPI-ePR Pilot Project that had migrated to the new eHRSS, eHRC advised that about 45 000 out of the 55 000-odd registered HCRs of eHRSS were hitherto participants of the PPI-ePR Pilot Project.

8. Mr POON Siu-ping noted that under the PPI-ePR Pilot Project, participating private healthcare professionals could access a defined scope of their patients' data from the electronic patient records of the Hospital Authority ("HA") subject to participating patients' consent. Noting that the transitional arrangement to allow the existing PPI-ePR participants to continue to use the PPI-ePR platform would continue for no less than two years, he asked about the arrangement for those PPI-ePR participants who, for various reasons, chose not to migrate to eHRSS upon the expiry of the transitional period. eHRC advised that the Administration would review the position in the third year of eHRSS operation and then decide the way forward.

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9. Dr LEUNG Ka-lau expressed dissatisfaction that the Administration had not mentioned to the Bills Committee on Electronic Health Record Sharing System Bill ("the Bills Committee") that it would cease to accept new applications to join the PPI-ePR Pilot Project upon the commencement of operation of eHRSS. In his view, the above arrangement would undermine the interests of patients as those patients who did not wish to join eHRSS until the availability of a feature to foster registered HCRs' choice over the scope of data sharing were denied to join the PPI-ePR Pilot Project to enjoy the benefits of one-way sharing. The existing 450 000-odd PPI-ePR participants would also become unable to enjoy the benefits of one-way sharing if they sought consultation from a private healthcare professional who had not joined the PPI-ePR Pilot Project beforehand. Mr Albert CHAN expressed a similar concern. He asked about the processing time for registration submitted by HCPs for joining eHRSS. Mr YIU Si-wing and Dr Elizabeth QUAT called on the Administration to put in place measures to shorten the time required by by the Electronic Health Record Office ("eHR Office") to process the registration from HCPs. Mr YIU Si-wing suggested that processing priority should be accorded to those HCPs which had not enrolled in the PPI-ePR Pilot Project.

10. eHRC stressed that the Administration had made it clear to the Bills Committee that since some PPI-ePR participants might need some time to consider whether to migrate to the new eHRSS, there would be a reasonable transitional period during which the existing PPI-ePR participants could continue to use the PPI-ePR platform until it was eventually decommissioned. The eHR Office had started to invite, from December 2015, existing PPI-ePR users to pre-register for eHRSS. eHRC further explained that the positive response from HCPs during the initial period of the eHRSS launch had made the processing of registration a resource demanding task. By deploying more manpower to process the registration, the eHR Office would normally be able to approve the registration within two weeks upon receipt of all relevant registration documents from the HCPs concerned, followed by the technical set-up and user account creation. This apart, the registration procedures and the registration form had been further simplified to make it more convenient to HCPs. It should also be noted that where necessary, patients could approach their existing HCPs, including HA, to make a data access request for hard copies of their health records and forward the copy of such records to those HCPs who had neither joined the PPI-ePR Pilot Project nor eHRSS.

11. Dr KWOK Ka-ki considered that the Administration should continue to accept new applications to join the PPI-ePR Pilot Project for the benefits of patients. eHRC explained that the Administration disagreed with this proposition in principle and had no plan to re-accept new applications for the Pilot Project. The PPI-ePR Pilot Project was launched in 2006 as a pilot project to test the concept, operational workflow and relevant technologies of

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electronic patient record sharing. It had fulfilled its mission as a pilot upon the launch of eHRSS**.** The Administration's stance was to encourage patients to opt for eHRSS, which would bring greater benefits to patients than PPI-ePR. In the Administration's view, if the size and number of PPI-ePR users were to continue to increase, it would not be conducive to the transition from PPI-ePR to eHRSS**.** The aforementioned transitional period was to cater for the interests of existing PPI-ePR users, while new applications to join PPI-ePR would not be accepted during the period.

12. The Chairman asked whether consideration could be given to connecting the PPI-ePR platform with eHRSS in order to address members' concern that the interests of patients were undermined under the existing transitional arrangement. eHRC replied that participation of HCPs and HCRs in eHRSS was voluntary and the Administration could not force PPI-ePR users to join eHRSS. In addition, registered HCRs needed to give a separate sharing consent to particular HCPs they selected, such that the HCPs concerned could obtain their sharable data from eHRSS.

Technical support for eHRSS

13. Referring to a recent incident of malfunctioning of the Clinical Management System ("CMS") of HA, Mr Charles MOK expressed concern about the safeguard against similar incident for eHRSS. Consultant (eHealth), eHR Office advised that the technical risk of eHRSS was lower than that of CMS, as the latter was of a more complicated environment and had a lot more transactions. That said, HA would consider whether there were any lessons that could be shared with the Electronic Health Record Office. In response to Mr Charles MOK's enquiry as to whether the improvement work to enhance CMS in the future would affect the technical manpower support for eHRSS, Consultant (eHealth), eHR Office advised that there was no immediate concern but the overall supply of IT manpower in Hong Kong would be kept in view.

Stage two Electronic Health Record Programme

14. Mr Albert CHAN enquired about the timetable for Chinese medicine practitioners to take part in the sharing of electronic health records. Dr Elizabeth QUAT asked about the progress of the study on the development of some form of new device or arrangement so as to give additional choices for HCRs over the disclosure of their health data in eHRSS. eHRC advised that the development of a Chinese medicine clinical management system suitable for adoption by Chinese medicine practitioners in the private sector, as well as the study referred to by Dr Elizabeth QUAT would be carried out during the second stage Electronic Health Record Programme. The Administration planned to seek approval from the Finance Committee ("FC") on the funding

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commitment for the second stage Electronic Health Record Programme in 2016-2017.

Motion

15. Dr LEUNG Ka-lau moved the following motion which was seconded by Dr KWOK Ka-ki:

"本委員會促請政府及醫院管理局盡快恢復「公私營醫療合作 — 醫療病歷互聯試驗計劃」的原有運作，包括接受新的病人及醫護提供者登記。"

(Translation)

"That this Panel urges the Government and the Hospital Authority to expeditiously resume the original operation of the Public-Private Interface - Electronic Patient Record Sharing Pilot Project, including accepting enrolment from new patients and healthcare providers."

16. The Chairman ruled that the motion was related to the agenda item under discussion, and invited members to consider whether the motion should be proceeded with at this meeting. Members agreed.

17. The Chairman put the motion to vote. The results were: four members voted in favour of the motion, no member voted against it, and one abstained. The Chairman declared that the motion was carried.

IV. Injection to the Health and Medical Research Fund

[LC Paper Nos. CB(2)1269/15-16(05) and (06)]

18. Under Secretary for Food and Health ("USFH") briefed members on the Administration's proposal to inject $1,500 million into the Health and Medical Research Fund ("HMRF"), details of which were set out in the Administration's paper (LC Paper No. CB(2)1269/15-16(05)).

19. Members noted the updated background brief entitled "Health and Medical Research Fund" prepared by the LegCo Secretariat (LC Paper No. CB(2)1269/15-16(06)).

20. 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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Eligibility for HMRF

21. Dr Helena WONG asked whether grants under HMRF would be awarded for research in tertiary institutions funded by UGC, and if so, how the funding scope of HMRF was different from that of the research funding schemes of the University Grants Committee ("UGC") and its Research Grants Council ("RGC"). Mr Albert HO raised a similar question. Noting that a Research Fellowship Scheme was launched under HMRF in August 2015, Dr Helena WONG sought elaboration about the eligibility for, and the funding arrangements of, the Scheme. The Chairman asked whether there was any undertaking for the applicants awarded with a fellowship.

22. USFH advised that research projects funded by RGC covered a range of disciplines, whereas the aim of HMRF was to build research capability and to encourage, facilitate and support health and medical research to inform health policies; improve population health; strengthen the health system; enhance healthcare practices; advance standard and quality of care; and promote clinical excellence. HMRF was governed by a Research Council chaired by the Secretary for Food and Health. For the investigator-initiated research projects, HMRF would invite research grant proposals from individual researchers in response to open call invitations for research grant applications. All eligible applications would be required to undergo a stringent two-tier peer review. The commissioned research programmes were by specific invitation only. As regards the Research Fellowship Scheme, tertiary institutions funded by UGC would be invited to nominate their full-time employees as fellowship applicants. The Scheme aimed to support researchers or professionals in their early to mid-career, particularly healthcare professionals, to enhance their skills in public health research. Consultant (Research Office) ("Consultant(RO)") supplemented that each application had to cover a local or overseas training programme or attachment and a research project relating to the proposed training programme. The awardees were required to submit to the Research Council interim reports as well as a final report of the training and the research project.

23. Dr Helena WONG asked whether applicability was one of the criteria in assessing the scientific merit of each grant application for investigator-initiated research projects. Dr KWOK Ka-ki raised a similar question. USFH replied in the positive. Consultant(RO) advised that the two-tier peer review would assess the scientific merit of the projects which included originality, significance of the research questions, quality of scientific content, credibility of design and methods and applicability to the local context.

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24. Dr KWOK Ka-ki considered that HMRF should accord funding priority to those applications from local academics or healthcare practitioners. USFH advised that for the investigator-initiated studies, all principal applicants to HMRF's open call for invitations should be based in a Hong Kong institution throughout the project period and be employed by the administering institution at the time of submission of application. Dr KWOK Ka-ki requested the Administration to provide in writing information on the breakdown of the 634 investigator-initiated research projects by local and Mainland researchers based in Hong Kong institutions.

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25. Mr CHAN Kin-por asked whether an appeal mechanism was in place for unsuccessful grant applicants to seek review of their applications. USFH advised that these applicants would be provided with comments of the Research Council regarding their applications. They could submit another application during the next round of invitation for applications.

Contribution of HMRF

26. Dr KWOK Ka-ki enquired about the measurement to assess the value of the HMRF projects to local research in health and medicine. Mr Albert HO considered that the Administration should assess whether the HMRF projects had considerable impact in terms of publications in international academic journals.

27. USFH and Consultant(RO) advised that HMRF projects that had been completed for at least two years would be evaluated using an instrument developed by the Food and Health Bureau based on the internationally validated Buxton-Hanney research payback questionnaire, which was a widely used instrument to quantify the outputs and outcomes of publicly-funded health and medical research. The self-completed questionnaire measured the research impact in several domains including knowledge production, utilization of research findings by the healthcare system, capacity building, impact on policy, behaviour change in research end-users and dissemination of research findings. At the request of Dr KWOK Ka-ki, USFH agreed to provide after the meeting a summary of the outcomes of the evaluation.

Admin

28. Mr Albert CHAN considered it of utmost importance that the funding support should be dedicated to research projects which sought to enhance local clinical practice as well as address the health and medical needs of the local population. Mr CHAN Kin-por sought information about the HMRF projects which had contributed significantly to informing health policy. USFH advised that cases in point included the cost-effectiveness analysis studies on universal pneumococcal vaccination of infants and various colorectal cancer screening

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strategies, and a study on the use of poultry avian influenza vaccine. At the request of Mr Albert CHAN, USFH undertook to provide a breakdown of the funded projects by the amount of grant and the number of local residents that had benefited from the research findings. In response to the Chairman's enquiry as to whether details of the projects supported by HMRF were made public, USFH advised that a full list of the research projects was available at the website of the Research Fund Secretariat.

Admin

The Health Care and Promotion Fund

29. Dr Helena WONG asked whether applications for the Health Care and Promotion Fund ("HCPF") were subject to two-tier peer review same as that of HMRF. USFH explained that the scope of HCRF was to focus primarily on health promotion activities and disease prevention. Funding applications for HCRF were reviewed by the Promotion Subcommittee under the Health Care and Promotion Fund Committee. USFH further said that to create synergy and provide more flexibility in the support of health and medical research and healthcare and promotion efforts, the Administration planned to expand the scope of HMRF to incorporate that of HCPF. Dr Helena WONG requested the Administration to provide in writing the rationale for appointing the persons as set out in Annex C to the Administration's paper as members of the Health Care and Promotion Fund Committee. USFH agreed.

Admin

Conclusion

30. In closing, the Chairman concluded that the Panel did not object the submission of the proposal to FC for consideration. The Chairman requested the Administration to provide in its paper for submission to FC the information requested by members as set out in paragraphs 24, 27, 28 and 29 above.

V. Consultation Report on Regulation of Private Healthcare Facilities

[LC Paper Nos. CB(2)1269/15-16(07) and (08)]

31. USFH briefed members on the outcome of the public consultation on the regulation of private healthcare facilities ("PHFs") and the way forward for revamping existing regulatory regime for PHFs, details of which were set out in the Administration's paper (LC Paper No. CB(2)1269/15-16(07)).

32. Members noted the updated background brief entitled "Regulation of private healthcare facilities" prepared by the LegCo Secretariat (LC Paper No. CB(2)1269/15-16(08)).

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Categories of PHFs to be regulated

33. Dr Helena WONG asked whether PHFs providing Chinese medicine services would be covered in the new regulatory regime. USFH replied in the negative, adding that the categories of PHFs to be regulated under the proposed regulatory regime were hospitals, day procedure centres, and clinics under the management of incorporated bodies.

Complaints management system

34. Dr KWOK Ka-ki remarked that the existing two-level complaints system of HA could not effectively handle the complaints against public hospitals. In his view, an independent mechanism should be put in place to handle all medical complaints. USFH advised that HA was empowered under section 5(m) of the Hospital Authority Ordinance (Cap. 113) to establish and maintain a system for providing a proper consideration of complaints from users of hospital services, or of members of the public, in relation to hospital services. The two-level complaints handling system of HA had been proved to be effective in handling complaints against public hospitals. It was against this backdrop that it was proposed that a two-tier complaints management system should be established to handle complaints against private hospitals.

35. Holding the view that mediation and arbitration were effective means to resolve medical disputes, Dr KWOK Ka-ki considered that the proposed Committee on Complaints against Private Hospitals ("the Complaints Committee") should introduce mediation and arbitration as options to handle complaints unresolved at service delivery level, instead of adopting an adversarial approach as that of the complaint investigation mechanism of the Medical Council of Hong Kong.

36. Dr Helena WONG asked under which circumstances should a party aggrieved by the service provided by a private hospital lodge the complaint with the Complaints Committee and the healthcare professional regulatory bodies. Assistant Director of Health advised that the party concerned could first lodge a complaint with the private hospital concerned. Unresolved cases at the service delivery level would be escalated to the Complaints Committee for investigation through a centralized and independent mechanism. If there was a case of possible professional misconduct of the healthcare professionals concerned, the Complaints Committee would refer the case to the relevant professional regulatory bodies for investigation as to whether or not a disciplinary inquiry should be conducted.

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Sanctions

37. Referring to the proposal to impose more severe sanctions on non-complying PHFs under the revamped regulatory regime, Dr KWOK Ka-ki considered that other than the person appointed as person-in-charge of the PHF concerned, the owner(s) should also be liable for the default.

38. USFH responded that the offence provisions had to be carefully crafted to deter serious non-compliance on the one hand, and on the other hand to avoid placing unduly onerous responsibility to be borne by the relevant officers in PHFs. The Administration would critically consider the scope and level of penalties in drafting the legislation.

Price transparency

39. Mr Albert CHAN expressed concern about the excessive service fees of doctors in private practice for performing operations. Making reference to the appointment of taxing masters for making an impartial assessment of the legal costs incurred by a party in proceedings, he suggested that the Administration should set up an independent mechanism for handling disputes over the service charges of doctors.

40. USFH advised that under the new regulatory regime, private hospitals would be required to provide to prospective patients a budget estimate as a plausible reference of the quantum of overall charge for their consideration on or before admission, and publish key historical statistics on their actual bill sizes for common treatments or procedures as prescribed by the regulatory authority. The above apart, PHFs would be required to make public their fee schedules covering all chargeable items and provide on a voluntary basis recognized service packages.

Regulation of provision of beauty services

41. Referring to the malpractices of some unscrupulous beauty services companies, Dr KWOK Ka-ki considered that the Food and Health Bureau, the Commerce and Economic Development Bureau and other relevant Bureaux should join hands to explore the possibility of introducing a licensing regime to regulate the provision of beauty services.

42. USFH responded that the beauty industry had run and evolved in a free-market environment subject to laws and regulations of a general nature. Most practices of the beauty industry were non-invasive and posed low health risks to customers. Instead of regulating the beauty industry indiscriminately, the Government has adopted a risk-based approach to focus on the high risk

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procedures which may cause unnecessary harm or complications to customers if performed by a person without proper training or qualification. Hence, the Working Group on Differentiation between Medical Procedures and Beauty Services set up under the Steering Committee on Review of Regulation of PHFs had identified those cosmetic services that should only be performed by registered medical practitioners or registered dentists.

VI. Organ donation

[LC Paper Nos. CB(2)836/15-16(07) and (08)]

[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.]

43. USFH briefed members on organ donation in Hong Kong and the Administration's proposal to step up the promotional effort for organ donation, details of which were set out in the Administration's paper (LC Paper No. CB(2)836/15-16(07)).

44. Members noted the background brief entitled "Organ donation" prepared by the LegCo Secretariat (LC Paper No. CB(2)836/15-16(08)).

Consent for organ donation

45. Mr Albert CHAN considered that the Administration and HA should put in place measures to address the issue that the deceased patients' families might not give their consent for donation of the organs of the deceased even the latter had expressed their wish to donate organs after death. USFH advised that prospective donors were encouraged to register their wish to donate organs after death through the Centralised Organ Donation Register ("CODR") established by the Department of Health, and share their wish with their family members. Director (Cluster Services), HA supplemented that in the past few years, all of the family members of those brain stem dead patients who had expressed their wish to donate organs beforehand respected the latters' wish to do so.

46. In response to Dr Helena WONG's enquiry about the major difficulty encountered by Organ Donation Coordinators of HA in their work, Organ Donation Coordinator, HA advised that for those cases whereby the brain stem dead patients had not indicated whether they wished to donate organ after death, about half of their family members, in midst of the emotional distress of the death of the deceased, would not agree to donate the deceased's' organs as they were uncertain about the wish of the deceased in this regard.

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Promoting organ donation

47. Mr Albert CHAN expressed concern that the number of cases of organ donation was much lower than the number of patients waiting for organ and tissue transplantation. He considered that the Administration should strengthen public education on organ donation, say, through inviting patients waiting for transplant or their family members to appeal for organ donation through the media. Dr Helena WONG suggested that the Committee on Promotion of Organ Donation ("the Committee") to be established in the first half of 2016 should devise measures to incentivize members of the public to donate their organs after death. For instance, organ donors could be entitled to priority in the allocation of niches at public columbaria. Expressing disappointment that there were only around 29 000 new registrations at CODR in 2015, Dr KWOK Ka-ki shared Dr Helena WONG's view. He considered that the Administration should allocate more resources for promoting organ donation and set a target to increase the number of registrations at CODR.

48. USFH agreed that there was room for further increasing the number of registrations at CODR. At present, the strategies for promoting organ donation would focus on encouraging registration at CODR and expression of one's wish of organ donation to family members and friends. The first meeting of the Committee would be held in April 2016 to formulate the organ donation promotional strategy and direction, and its work plan to collaborate with other partners in conducting the promotional activities. The Administration would keep in view that the measures put in place to promote organ donation would adhere to the World Health Organization's Guiding Principles on Human Cell, Tissue and Organ Transplantation. Separately, it would assess more in-depth the public's understanding and acceptance of organ donation, including an opt-out system, through the Thematic Household Survey conducted by the Census and Statistics Department.

VII. Any other business

49. There being no other business, the meeting ended at 6:50 pm.

Council Business Division 2
Legislative Council Secretariat
28 September 2016