立法會
Legislative Council

LC Paper No. CB(2)770/00-01
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

LegCo Panel on Health Services

Minutes of meeting
held on Monday, 8 January 2001 at 8:30 am
in Conference Room A of the Legislative Council Building

Members Present	:	Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP (Chairman) Dr Hon LO Wing-lok (Deputy Chairman) Hon Cyd HO Sau-lan Hon CHAN Yuen-han Hon Bernard CHAN Dr Hon YEUNG Sum Hon Andrew CHENG Kar-foo Hon LAW Chi-kwong, JP Dr Hon TANG Siu-tong, JP Hon LI Fung-ying, JP Hon Tommy CHEUNG Yu-yan, JP Hon Michael MAK Kwok-fung
Members Attending	:	Hon Fred LI Wah-ming, JP Hon NG Leung-sing Hon Audrey EU Yuet-mee, SC, JP
Public Officers Attending	:	Mr Gregory LEUNG, JP Deputy Secretary for Health and Welfare Dr W M KO Deputy Director (Operations & Public Affairs) Hospital Authority

Action

Dr S P MAK, JP
Deputy Director of Health (Special Duties)

Mr Eddie POON
Principal Assistant Secretary for Health and Welfare

Clerk in Attendance : Ms Doris CHAN
Chief Assistant Secretary (2) 4

Staff in Attendance : Miss Mary SO
Senior Assistant Secretary (2) 8

I. Confirmation of minutes of meeting held on 12 December 2000
(LC Paper No. CB(2)574/00-01)

The minutes of the above meeting were confirmed.

Withdrawal of membership

2. Before proceeding to the next agenda item, the Chairman informed members that Mr WONG Yung-kan had informed the Secretariat on 5 January 2001 that he wished to withdraw from the Panel with immediate effect.

Proposed research study on regulation of medicines in Australia

3. The Chairman sought members' view on her proposal to request the Research and Library Services Division to conduct a research on the regulation of medicines in Australia. Members expressed support.

II. Date of next meeting and items for discussion
(LC Paper Nos. CB(2)577/00-01(01) - (02))

4. Members agreed to discuss Chapter 4 of the Consultation Document on Health Care Reform (the Consultation Document) on the reforms to the system of quality assurance at the next regular meeting to be held on 12 February 2001, and to discuss Chapter 5 of the Consultation Document on the options for financing health care service at the regular meeting on 12 March 2001.

Action

III. Reforms to the service delivery system (Paragraphs 13 to 78 of the Consultation Document on Health Care Reform)

5. At the invitation of the Chairman, Deputy Secretary for Health and Welfare (DSHW) gave a power point presentation on the reforms to the service delivery system detailed in paragraphs 13 to 78 of the Consultation Document.

6. Noting the proposal to transfer the Department of Health (DH)'s general out-patient service to the Hospital Authority (HA), Dr YEUNG Sum expressed concern that such a move would not only increase the already heavy workload of HA but would also aggravate the present uneven distribution of workload between the public and private sectors. Dr YEUNG further expressed concern about the slow progress made in the development of primary care and family medicine, and enquired whether the Consultation Document had adequately addressed such deficiencies.

7. Deputy Director, Hospital Authority (DDHA) responded that HA had no intention to change the existing arrangement whereby primary care was predominantly provided by general practitioners in the private sector. He explained that one of the reasons for transferring DH's out-patient service to HA was to facilitate continuity of care through the primary and secondary levels in the public sector. He pointed out that although there was at present regular liaison between the two organisations on the referrals to and from HA's specialist out-patient clinics, and shared care programmes, such as those for diabetic patients, had been implemented, the different environments in which the staff had to work had nevertheless given rise to interfacing problems. Another reason for the transfer was that these clinics would also serve as training ground for family medicine and other primary care practice. Effectively carried out, the functions of primary care practitioners could help reduce significantly the pressure on secondary and tertiary care and the overall health care expenditure of the community. This was in line with the international trend which had been to focus on the development of the more cost-effective ambulatory and community care programmes, and to replace, as far as possible, in-patient treatment by out-patient services.

8. DDHA further said that the implementation of the proposal to transfer DH's out-patient service to HA should not greatly increase the existing workload of HA, as much time and efforts would be saved from improved coordination between primary and secondary levels of care. He also pointed out that the HA Board was equally concerned about the uneven distribution of workload between the public and private sectors. To this end, HA would explore ways to improve collaboration with the private sector in the development of family medicine practice. The possibility of contracting out some of HA's services to private sector should not be excluded.

Action

9. Responding to Dr YEUNG's concern about the slow progress made in the development of primary care and family medicine, DSHW said that the Administration had the determination to improve such. A case in point was that apart from starting a family medicine training programme in 1997-98 and setting up family medicine-based clinics to assist the specialist out-patient clinics by attending to patients in stablised conditions, HA planned to provide training to a total of 316 family medicine trainees in 2001-02, and in the longer term, about half of the doctors recruited to the public sector would be trained in family medicine and primary care.

10. Mr Andrew CHENG noted that under the new funding arrangement based on population and demographic profiles instead of hospital beds and facilities, HA would focus on the development of ambulatory and community care. Mr CHENG expressed concern that in so doing, health care services to the public would be undermined. As patients would be asked to leave the hospitals earlier and convalesce at home because of reduced emphasis on in-patient hospital services, he was worried whether the provision of ambulatory and community care, which was still in its developmental stage, was adequate to cope with patients' needs. To allay public's concern in this regard, the Administration should throw more light on how it planned to implement a community-based health care service to complement in-patient hospital services, such as the number of day treatment centres and multi-services social centres which would be built, the timing of their provision, their location and the amount of money which would be set aside to fund these new facilities.

11. DSHW responded that placing emphasis on the provision of ambulatory and community care did not mean that in-patient hospital services would be reduced. HA would continue to build new hospital facilities to meet patients' needs, as evidenced by the fact that proposals to expand Ruttonjee Hospital and to redevelop Pok Oi Hospital would shortly be submitted to the Finance Committee of the Legislative Council for approval. New hospitals would also continue to be built, in line with population needs, through funding from the Capital Works Reserve Fund. The reason for developing ambulatory and community care was to ensure that resources would be deployed in the most cost-effective manner. He pointed out that with the advances in medical technology, more and more patients no longer required hospitalisations after treatment. Likewise, people suffering from chronic illnesses would no longer require frequent or long hospitalisations if adequate ambulatory and community care was provided to them. Notwithstanding this, DSHW assured members that the development of ambulatory and community care would be conducted in a gradual and cautious manner to ensure that the health care needs of the public would not be undermined. DSHW further said that funding to HA would not necessarily be reduced under the new funding arrangement. According to calculations based on population growth and aging, not taking into account other factors for the time being, HA's recurrent budget for the next three years might increase in the region of 2.2% to 2.3% per annum. Regarding Mr CHENG's request for more information on how the Administration planned to proceed with the implementation of a community-based health care delivery, DSHW

Action

said that as such implementation was a long-term process, members would be briefed periodically in the next few years when more concrete proposals had been drawn up.

12. Noting that new funding to HA for the next three years might amount to some $600 million per annum (i.e. representing 2.2% to 2.3% of HA's recurrent budget of about $30 billion for the current financial year) under the new population-based funding arrangement, Mr Andrew CHENG enquired whether such new funding would exceed $600 million if the existing facility-based funding arrangement was used. DSHW responded that the amount of new funding which HA would receive for the next financial year should be more than that it had received for the current financial year, having regard to the fact that a similar number of new hospital beds to that commissioned in the current financial year, i.e. about 300 to 400, had been planned for commissioning in the next financial year and the provision of 300 to 400 new hospital beds certainly would not entail $600 million. In reply to Mr CHENG's further enquiry on HA's next year plan on the provision of in-patient hospital services and ambulatory and community care programmes, DSHW said that such information would be set out in the 2001-02 Budget to be announced by the Financial Secretary in March 2001.

13. Miss Cyd HO pointed out that the marked price difference was the most important reason for the present uneven distribution of workload between the public and private sectors. She wished to know whether a means test would be introduced to restrict the use of the highly subsidised public general out-patient services to primarily the financially vulnerable and the chronically ill. As tertiary care took up the lion's share of the public health care expenditure, Miss HO was of the view that the Administration should adopt the "money follows the patient" concept by subsidising better-off patients to go to the private hospitals. Apart from this, consideration could be given to granting tax concession for health care insurance premium. Miss HO further expressed support for the development of ambulatory and community care, but urged that no patients would be asked to leave the hospitals to convalesce at home unless their homes were suitable for convalescing. In this connection, Miss HO enquired whether there were any objective standards to assess the suitability of a patient's home for convalescing.

14. DDHA responded that although Hong Kong's cramped living environment and the fact that most of its people led a busy life were not conducive to patients convalescing at home, its small area with everything in close proximity to one another nevertheless provided a distinct advantage to the provision of home and community care. He pointed out that although many overseas countries had a better living environment than Hong Kong, more resources were required by the former to serve the same number of patients convalescing at home because of its large area and the fact that most of its living quarters were scattered wide apart. He assured members that no patients would be asked to leave hospitals and convalesce at home if their homes were not suitable for convalescing and/or did not have family members to take good

Action

care of them. Although only limited visits could be made to the patients' homes to ascertain their suitability for convalescing due to limited resources, HA staff would conduct interviews with the patients and their family members to gain a thorough understanding of the environment of the patients' homes. Based on the information received from the interviews, HA staff would use their professional judgement to assess whether the patients' homes were suitable for convalescing, or whether some minor modifications could be made to make these homes suitable for convalescing. DDHA further said that patients discharged from hospitals to convalesce at home would not be left on their own, as most hospitals had a hotline to which the patients and their carers could access to seek medical advice and assistance. Moreover, if the discharged patients were later diagnosed to require hospitalisation, arrangement would be made to re-admit them to the hospitals at the earliest possible time without the need for them to queue up for hospital beds along with the new patients.

15. Regarding Miss HO's suggestion of subsidising better-off patients to go to the private provider, DDHA expressed reservation about it as it was very difficult for HA to identify who was genuinely in need of subsidisation. DSHW supplemented that there was no quick and easy solution to narrow down the present uneven distribution of workload between the public and private sectors, having regard to the fact that the huge price differences between the two sectors provided no incentive for the public at large to go to the private hospitals for treatment. The Administration however did not wish to greatly raise the fees and charges of public hospitals or to interfere with the pricing of the private hospitals to rectify the existing lopsided situation. As there was a demand for private hospital services priced at a level affordable by the middle-class, HA would explore with the private sector to develop new health care products in which both the public and private sectors could participate, thereby expanding the patients' choice. DSHW further said that the proposed Health Protection Account scheme was a way to encourage people to go to the private sector, as savings from the Health Protection Accounts could be used to pay for medical or dental insurance plans.

16. Miss Cyd HO disagreed that the proposed Health Protection Account scheme would be able to encourage people to go to the private provider, as savings from the Health Protection Accounts would not be able to cover the medical bills of the private provider. She pointed that although some better-off patients preferred the services of the private provider, they nevertheless still went to the public hospitals for treatment because they did not know how much such services would cost in the end, and, more importantly, whether they could afford them. Miss HO further said that it would be useful to invite representatives from the medical profession and the insurance industry to give views on ways to attract better-off patients to the private sector. The Chairman said that there was no need to invite deputations to give their views as this stage, as the Administration was currently conducting public consultation on the matter.

17. Responding to Miss HO's comments that the reason why some better-off patients still went to the public hospitals was because they were uncertain about the

Action

medical costs of the private provider, DDHA said that to meet patients' needs, some private hospitals and private practitioners now offered some services at a packaged rate. HA could help to publicise such information to its patients so as to provide them with an alternative. He further said that in doing so, every effort had been made to ensure that the principle of equity would not be undermined and that no favoritism would come into play.

18. Mr Bernard CHAN said that although at present there were about 2.2 million health care insurance policies in Hong Kong, the overwhelming majority of them were group policies purchased by employers as their employees' benefit, while individual health care insurance policies only amounted to a very small number. Such a situation was understandable, as the highly subsidised fees and charges of the public hospitals provided no incentive for people to purchase their own health care insurance in order to go to the private provider. Mr CHAN further said that if the price differences between the public and private sectors remained huge, there was not much the insurance industry could do to attract people to purchase health care insurance. Dr LO Wing-lok echoed Mr CHAN's views.

19. DSHW said that HA would explore with the private sector on how both sides could collaborate and develop new health care products, so as to provide patients with more choices in medical treatment. The insurance industry would be encouraged to develop new health care insurance policies to support these new products. DSHW further said that he would be happy to provide the insurance sector with relevant statistics for assessment of underwriting such new health care insurance policies, and to discuss further with the sector in this regard.

20. The Chairman said that one possible way to improve the interface between the public and private sectors, which had been suggested by some members of the public and the Liberal Party, was to allow the private sector to buy hospital beds of the public hospitals.

21. Referring to paragraphs 33 and 34 of the Consultation Document, Dr LO Wing-lok enquired whether the services provided by HA would be increased or decreased. On the one hand, it was mentioned in paragraph 33 that DH's general out-patient service, upon transfer to HA, would be redesigned into clinics attending to primarily the financially vulnerable and those chronically ill but on the other hand, it was mentioned in paragraph 34 that some of HA's general out-patient services would be contracted out to private practitioners. Noting the HA's plan to provide training to a total of 316 family medicine trainees in 2001-02, Dr LO enquired whether at present there were adequate instructors to provide the training; and if not, whether recruitment would be made to make up for the staff shortfall and posts created to accommodate them.

22. Responding to Dr LO's first question, DSHW said that it was the

Action

Administration's intention that the present arrangement whereby the public sector providing 10% of the primary care in Hong Kong should remain unchanged after the transfer of DH's general out-patient service to HA. DSHW further said that patients currently receiving treatment from DH's general out-patient clinics should not be affected by the transfer, as they would continue to receive the same medical treatment under HA. As regards Dr LO's second question, DDHA said that HA currently did not have enough instructors to provide training to 316 family medicine trainees in 2001-01. It however envisaged that with more family medicine trainees completing their training in the next few years, the existing instructor shortage problem would be largely solved. To address the more immediate staff shortfall problem in the training of 316 family medicine trainees in 2001-02, private practitioners would be recruited to meet the need and posts would of course be created to accommodate them where necessary. DDHA further said that recruiting private practitioners as instructors in family medicine was not unprecedented, as plans had already been made to recruit private practitioners to provide training for doctors to work in HA's specialist out-patient clinics. At the request of Dr LO, DDHA agreed to provide information on the existing number of family medicine instructors after the meeting.

Adm

23. Miss LI Fung-ying enquired whether the fees and charges of HA's general out-patient clinics would be greatly increased, having regard to the fact that HA planned to contract out some of its general out-patient clinics to private practitioners. Miss LI further enquired whether registered Chinese medicine practitioners could refer patients to hospitals, which currently only practised western medicine, for follow-up treatment.

24. DSHW replied in the negative to Miss LI's first question, as public sector fees would be applied to those HA's general out-patient clinics contracted out to private practitioners. As regards Miss LI's second question, DDHA said that at present it was not possible for registered Chinese medicine practitioners to refer patients to hospitals for follow-up treatment, as how Chinese medicine could be integrated into the public health care system to provide treatment to patients in collaboration with western medicine was at a very early developmental stage. As there was no past experience to refer to for the integration of Chinese medicine in the public health care system in Hong Kong, HA intended to pilot the practice of Chinese medicine in selected public hospitals, supporting clinical research, and facilitating the development of standards and models of interface between western and Chinese medicines. Appropriate referral guidelines would also be formulated based on experience to support the collaboration. DSHW supplemented that building a hospital dedicated solely to Chinese medicine practice would not be considered, as it was the long term goal of the Administration that the public health care system could provide both Chinese and western medicines treatments to patients.

25. Noting that the Administration intended to encourage more private dental practitioners and non-governmental organisations (NGOs) to offer affordable dental care to the community, Dr TANG Siu-tong enquired whether this meant that DH and

Action

HA would no longer provide curative dental service to the public. Dr TANG further enquired about the Administration's thinking on how Chinese medicines could be integrated with western medicine to provide treatment to patients.

26. DSHW responded that given the constraint on public expenditure, it was necessary to use public funds in areas which could help achieve the best health outcome. In the case of oral health, the Administration considered that the public funds available should be primarily channeled to educational and preventive efforts, which would bring the best benefits to the population. The provision of curative care should therefore in general be provided by private dental practitioners and NGOs. Deputy Director of Health (DDH) also said that putting emphasis on promoting oral health awareness and oral hygiene practices was necessary, because there was in practice no complete cure once the teeth had decayed. To this end, DH would collaborate with the dental profession, the College of Dental Surgeons of Hong Kong and the Prince Philip Dental Hospital in formulating standards, setting oral health goals, conducting surveillance programmes, promoting the importance of oral health to the community and assuring quality throughout the profession. DH would also explore with the dental profession on how to introduce an oral health scheme for secondary students, as an extension to the school dental scheme for primary students provided by DH. DDH further said that although emphasis would be on educational and preventive efforts, DH would continue to provide emergency dental service to the general public through its 11 dental clinics, as well as subsidised curative service to persons with special needs, such as patients with HIV infection, severe physical or mental handicap. Responding to Dr TANG's second question, DSHW said that he could not yet give an answer to the question as the development of standards and models of interface between western and Chinese medicines was just beginning.

27. Mr Michael MAK queried why the section on strengthening of preventive care was not incorporated into the section on re-organisation of primary care in the Consultation Document, as primary care also included preventive care. As DH's general out-patient service would be transferred to HA, Mr MAK enquired whether the terms and conditions of employment of staff working in DH's general out-patient clinics would be changed as a result of the transfer. Furthermore, in view of the fact that the management structure of DH's general out-patient clinics was different from that of HA, Mr MAK enquired which management structure HA would adopt on taking over the out-patient clinics from DH.

28. DSHW explained that creating two separate sections on strengthening of preventive care and re-organisation of primary care in the Consultation Document was for clarity purpose, as different people had different understanding of what primary care meant. He further said that although strengthening of preventive care and re-organisation of primary care were mentioned separately in the Consultation Document, these two areas would be given equal importance in the provision of public health care. On the question of the terms and conditions of DH staff transferred to HA, DSHW

Action

said that staff affected would be given a choice to either stay in DH or transfer to HA. If the latter decision was taken, the staff concerned would be allowed to retain their civil service employment terms. This was nothing new, as at present about 4 000 HA staff were on civil service employment terms. DSHW further assured members that no staff would be forced to resign as a result of the transfer of DH's general out-patient clinics to HA. As regards the mode of operation which HA would adopt on taking over the out-patient clinics from DH, DSHW said that HA was considering the issue and HA planned to try out the new mode in five general out-patient clinics next year.

29. Miss CHAN Yuen-han said that the Consultation Document failed to facilitate constructive discussion, as the proposals contained therein did not contain any details. She enquired whether the Administration had any hidden agenda for the health care reform. Miss CHAN further expressed concern that the Consultation Document had not adopted many proposals recommended by the Harvard consultants.

30. DSHW responded that the Administration had no hidden agenda for the health care reform. The reason why the proposals contained in the Consultation Document only provided an outline was because the Administration would like to know the views of the public on them before formulating detailed plans of implementation. The public would be consulted again after such detailed plans had been formulated. In view of the complexity of the health care reform and its far-reaching effect on the public, it was prudent to take the health care reform forward in a paced and cautious manner. DSHW further said that the Consultation Document had incorporated many proposals recommended by the Harvard consultants, such as proposals to rectify the existing lack of effective interface and collaboration between the public and private sectors. At the request of the Chairman, DSHW agreed to provide a paper setting out the proposals which the Harvard consultants had recommended and how they had been followed up by the Administration in the Consultation Document.

Adm

31. Dr YEUNG Sum enquired whether the fees and charges of the public hospitals would be greatly increased, so as to force patients to go to the private provider. DSHW reiterated that the Administration would not do so.

32. Miss Cyd HO asked whether the public had a say in determining how public funds could be spent on the provision of health care services, having regard to the facts that it was stated in paragraph 12(g) of the Consultation Document that the community was entitled to expect that public resources were used efficiently, and that public subsidies were targeted at areas of greatest needs, whereas it was stated in paragraph 25 of the same that DH would carry out health impact assessment of socio-economic variables and different environmental problems and then would base on these efforts to form the basis to support the formulation of health priorities, targets and strategies. DSHW responded that paragraph 25 referred to the formulation of health priorities, targets and strategies relating to preventive care. He further said that the public would be consulted in the usual manner on how public funds should be

Action

deployed in the provision of public health care.

IV. Any other business

33. There being no other business, the meeting ended at 10:34 am.

Legislative Council Secretariat
8 February 2001