立法會
Legislative Council

LC Paper No. CB(2)1257/04-05
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of special meeting
held on Monday, 31 January 2005 at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Hon Andrew CHENG Kar-foo (Chairman) Dr Hon KWOK Ka-ki (Deputy Chairman) Hon Albert HO Chun-yan Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP Hon Bernard CHAN, JP Dr Hon YEUNG Sum Hon LI Fung-ying, BBS, JP Hon Vincent FANG Kang, JP Hon LI Kwok-ying, MH Dr Hon Joseph LEE Kok-long Hon Albert Jinghan CHENG
Members absent	:	Hon CHAN Yuen-han, JP Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP
Members attending	:	Hon WONG Kwok-hing, MH Dr Hon Fernando CHEUNG Chiu-hung Hon KWONG Chi-kin
Public Officers attending	:	All items Miss Susie HO, JP Deputy Secretary for Health, Welfare & Food (Health)

Action

Items I and II

Mrs Ingrid YEUNG
Principal Assistant Secretary for Health, Welfare & Food (Health) 2

Dr William HO, JP
Chief Executive, Hospital Authority

Dr Allen W L CHEUNG
Director (Professional Services & Operations)
Hospital Authority

Item I

Dr Beatrice CHENG
Senior Executive Manager (Professional Services)
Hospital Authority

Item III

Dr Anne FUNG
Senior Medical and Health Officer (Research Office)
Health, Welfare & Food Bureau

Clerk in attendance : Ms Doris CHAN
Chief Council Secretary (2) 4

Staff in attendance : Ms Joanne MAK
Senior Council Secretary (2) 2

I. Introduction of a standard drug formulary in Hospital Authority

(LC Paper Nos. CB(2)746/04-05(01), CB(2)786/04-05(01) and CB(2)800/04-05(01))

At the Chairman's invitation, Director (Professional Services & Operations) (D(PS&O)) gave a Powerpoint presentation on the proposed introduction of a Standard Hospital Authority (HA) Drug Formulary (Standard Drug Formulary) in the public hospital system. He informed members that HA would launch a three-month public consultation on the proposal and it intended to implement the Standard Drug Formulary in the first half of 2005.

Action

2. Dr KWOK Ka-ki, Dr Joseph LEE and Mr Vincent FANG declared that they were members of the HA Board.

3. Dr KWOK Ka-ki considered that the framework of the Standard Drug Formulary did not seem to reflect the targeted subsidy principle earlier mentioned by the Secretary for Health, Welfare and Food, who had said that public hospitals would cater for the poor, the chronically ill patients, and patients suffering from high-risk ailments. Dr KWOK pointed out that under the current proposal, while public hospitals would continue to provide inexpensive drugs for curing low-risk ailments such as ordinary diabetes and high blood pressure, the cost of effective but expensive drugs like Imatinib (Glivec) for treatment of Gastrointestinal Stromal Tumour (GIST) would have to be paid by patients. Dr KWOK asked whether the Standard Drug Formulary would be regularly reviewed and whether a transparent and open mechanism would be put in place for determining what drugs should be included in or removed from the Standard Drug Formulary. Dr KWOK also expressed concern about the adequacy of the Samaritan Fund in subsidising patients and he asked for more information on the criteria for assessing a patient's eligibility for exemption from payment of drug charges under the current proposal.

4. In response, Chief Executive of HA (CE/HA) said that at present, for inpatients at public hospitals and outpatients at General Outpatient Clinics, the provision of drugs was covered by the basic fee charged by HA. For outpatients at Specialist Outpatient Clinics, the drug charge was $10 per drug item. He pointed out that while the Government and HA wished to explore in the direction of the targeted subsidy principle, no changes would be made to the present charging policy for drugs before any such changes had been discussed by the public. CE/HA said that under the current proposal, the category of General Drugs in the Formulary would be provided within the standard fees and charges at public hospitals and clinics i.e. the drug charge would either be covered by the basic fee or the drug charge would only be nominal. CE/HA added that the present percentage of patients who obtained non-standard drugs via a safety net was actually very small.

5. CE/HA further said that HA would thoroughly consult doctors and specialists of HA as well as patients groups for their views on the drugs to be included in the Formulary. As to the fee waiver mechanism for drugs, CE/HA explained that as with the existing medical fee waiver mechanism, waivers would be granted upon the recommendation of Medical Social Workers (MSWs). He stressed that it had always been the Government's principle that no one would be denied adequate medical care due to lack of means. As regards the adequacy of the Samaritan Fund, CE/HA said that the Fund had all along relied on charity donations and Government provision and it was possible for the Fund to become inadequate if the number of eligible patients was on the rise. He remarked that

Action

many overseas countries were also unable to provide expensive drugs for patients. HA had tried to introduce drugs of proven efficacy, though expensive, by resorting to different ways. He said that in some cases where patients could not afford the high costs of certain expensive drugs on a long-term basis, apart from resorting to the Samaritan Fund, HA had negotiated with the pharmaceutical producers concerned for discounts for the patients concerned.

6. Dr KWOK Ka-ki further asked whether a mechanism would be put in place for patients to appeal against HA's decision to remove any drug item from the Standard Drug Formulary. D(PS&O) responded that HA had maintained regular contacts with patients groups to understand and address their concerns. In addition, patients could reflect their views on drug matters to their doctors during consultation and the doctors would relay such views to the management of HA.

7. Responding to CE/HA's remarks in paragraph 5 above, the Chairman said that many overseas countries could not afford paying such high remuneration packages to management staff as those paid to the HA senior management team. Deputy Secretary for Health, Welfare & Food (Health) (DSHWF) responded that HA had recently appointed an external consulting firm to conduct a thorough review of the remuneration packages of the senior executive team with outcomes to be deliberated by the HA Board during the first quarter of 2005.

8. Mr Albert HO considered that the genuine purpose of the introduction of the Standard Drug Formulary in the public hospital system was to increase incomes of HA in order to reduce the deficit of HA. Referring to paragraph 13(a) of the paper, Mr HO expressed serious concern about the proposal that drugs proven to be of significant benefits but expensive would have to be self-financed by patients. He pointed out that this would represent a fundamental change in the public health policy which had all along been that public hospitals provided the same medical treatment to patients with the same illnesses regardless of their affordability. He further said that although a safety net would be provided, those who by a narrow margin failed to meet the eligibility criteria for receiving subsidies might need to resort to their lifelong savings in order to pay for necessary drug charges.

9. In response, DSHWF said that the main objective of developing an HA-wide Standard Drug Formulary was to ensure equitable access to cost effective drugs of proven efficacy and safety, through standardisation of drug policy and utilisation in all HA hospitals and clinics. She pointed out that a few very expensive drug items were already self-financed by patients at present and the existing practice was that patients who could afford to pay were required to contribute whereas those who had genuine financial difficulty were granted assistance in respect of the drug cost. She said that the present number of patients purchasing Glivec at their own expenses was very small as few people could afford the high cost of the drug. She further said that those who were

Action

eligible for partial or full subsidy to pay for these expensive drugs under the present mechanism would continue to be entitled to subsidies after the introduction of the Standard Drug Formulary.

10. As regards the Samaritan Fund, DSHWF said that the Administration had in the past sought the approval of the Finance Committee (FC) for funding allocations to be made for the Samaritan Fund and the Administration did not exclude the possibility of having to apply for FC's approval again for further funding.

11. CE/HA said that the objective for introducing the Standard Drug Formulary in the public hospital system was not to save money. He pointed out that in fact, he had been told by individual hospital clusters that the introduction of the Standard Drug Formulary might lead to increases in drug expenditure of individual hospitals. He explained that this had reflected the long existing problem of lack of standardisation of the drug charging policy across public hospitals/clinics, resulting in a situation that patients could be required to pay for the cost of a drug in one hospital but not be required to do so at another. He further said that with regard to the use of resources, HA's first and foremost consideration was always patients' needs and it would, therefore, continue to introduce expensive drugs which had proved to be of significant benefits. He added that despite financial constraints, HA's drug expenditures had continued to be on the rise and HA would probably have a double digit increase in drug expenditures by the end of 2005.

12. Mr Albert HO, however, remained of the view that under the current proposal, there was a fundamental change in public health policy. He said that in the past, when patients were hospitalised, they would not be receiving different treatment because of their differences in affordability and anyway doctors would provide the best medication available. He further said that the new policy would not affect the worst-off people. However, the implications could be serious for the middle class or the middle/lower income groups. He pointed out that under the new policy, a person of such class/groups might have to spend all his money on a special drug when suffering from a serious illness. He said that the Democratic Party would not agree to the introduction of new medical fees on a gradual basis before the Administration had completed its review of healthcare financing and had worked out possible options. He therefore proposed deferring the introduction of the Standard Drug Formulary until after completion of the healthcare financing review.

13. DSHWF responded that the Administration would examine and work out healthcare financing options at the end of 2005. She pointed out that HA was obliged to ensure rational use of finite public resources and the introduction of the Standard Drug Formulary was to ensure equitable access to cost effective drugs through standardisation of drug policy and utilisation in all HA hospitals and clinics. The Administration was of the view that such measures could be

Action

implemented alongside the examination of healthcare financing options.

14. The Chairman asked whether HA could give an estimate of the additional cost that HA would incur if Glivec was included in the Standard Drug Formulary. Admin/HA CE/HA agreed to provide the information after the meeting.

15. Dr Fernando CHEUNG raised the following concerns regarding the current proposal -

(a) From patients' perspective, it was more justifiable for HA to subsidise the cost of those very expensive drugs which were required for treatment of serious illnesses than to subsidise inexpensive drugs which were affordable in general.

(b) Although the Administration claimed that there was a safety net for drugs outside the Standard Drug Formulary, it should be noted that applications for the Samaritan Fund were screened on the basis of the applicant's monthly household income which should not exceed a certain percentage of the Median Monthly Domestic Household Income (MMDHI), which was $15,000. For patients whose monthly household income was, say $15,500, which was just slightly above the MMDHI, they would be ineligible for subsidies to meet drug expenses even though the expenses were beyond their affordability.

(c) Some patients, especially the elderly, were worried that it would be very inconvenient if they had to purchase drugs from community pharmacies and they might have to pay variable prices for the drugs.

16. Dr CHEUNG also requested further information on drugs which were being subsidised by HA but would have to be self-financed by patients after the introduction of the Formulary, and the number of patients, categorised by types of diseases suffered, who would be affected. He further said that some patients found that HA had prescribed drugs for a shorter duration than before and patients had to go to the hospital pharmacies again before their next follow-up consultations were due. He added that as the introduction of the Standard Drug Formulary had aroused grave concern of patients groups, including the chronically ill, the elderly and the disabled, he proposed that the Panel should hold a special meeting to receive these people's views on the Formulary.

17. In response, CE/HA explained that it was not possible to have an impact study concerning the introduction of the Standard Drug Formulary because HA had, on an on-going basis, been reviewing and adjusting drug items in existing drug formularies on the basis of evidential support for the clinical efficacy of the drugs and medical professionals' advice. He reiterated that the introduction of

Action

the HA Standard Drug Formulary was aimed at clearly defining the range, choice, classification and indication for the use of drugs in order to ensure uniformity and equity across all HA hospitals and clinics. D(PS&O) added that with the introduction of the Standard Drug Formulary, objective consideration factors to determine what drugs should be classified as General Drugs or Special Drugs and what kinds of drugs could be provided to patients via the safety net mechanism would be clearly laid down.

18. With regard to the Samaritan Fund, CE/HA pointed out that the waiver mechanism for drugs would be administered by Medical Social Workers (MSWs), who would consider applications on a case-by-case basis, making reference to both financial and non-financial factors, such as a patient's clinical conditions, family problems, etc. He added that MSWs would exercise their discretion to grant waivers, where appropriate, to a patient with special difficulties on a case-by-case basis.

19. Ms LI Fung-ying also expressed concern about the impact of the introduction of the Standard Drug Formulary on patients, especially the chronically ill patients who had been put on drugs (e.g. Glivec) which would not be included in the Formulary.

20. DSHWF pointed out that there would only be very few types of drugs including Glivec which fell within the group of drugs as described in paragraph 13(a) of the paper and the number of patients affected would also be very small. She stressed that the present practice as explained in paragraph 9 above would remain unchanged after the introduction of the Standard Drug Formulary. CE/HA pointed out that the large majority of drugs required by patients were included in the Formulary and these drugs would be provided within the standard fees and charges. He said that there would not be substantial changes to the drug policy and utilization.

21. D(PS&O) added that if the prescription of drugs for a patient had to be adjusted with the introduction of the Formulary, this would be done on a gradual basis in order to minimise impact on the patient. He pointed out that doctors would exercise their discretion and flexibility in prescribing drugs. He also informed members that no drugs which were currently provided within the standard fees and charges would have to be obtained through the safety net mechanism in the future. He said that on the contrary, there would be certain drugs, which patients were at present required to pay for with safety net coverage, to be provided within the standard fees and charges after the introduction of the Formulary.

22. Dr Joseph LEE pointed out that patients would not be able to comment on the introduction of the Formulary during the consultation process if they did not understand much about it. D(PS&O) said that in the process of preparing the

Action

draft Standard Drug Formulary, HA had briefed professional staff groups and patients groups on the rationales and needs for the development of a Standard Drug Formulary and invited their views on the proposal. HA would further consult their views and arrange discussions on the Formulary through various channels including the mass media and would consult District Councils. In addition, HA was going to upload the draft Standard Drug Formulary onto the website of HA for perusal by the public.

23. In response to Dr Joseph LEE's questions, D(PS&O) said that it was planned that the future Standard Drug Formulary would be reviewed and modified once every 12 to 18 months and in the process, the views and comments of patients groups would be taken into account. He added that there was already an established mechanism for determining new drugs to be introduced and the mechanism would continue to function after the introduction of the Formulary. D(PS&O) added that in determining which types of drugs that could be provided via the safety net mechanism, HA was guided by the principles of evidence-based efficacy and consideration of cost effectiveness.

24. Referring to paragraph 18(c) of the paper, Dr Joseph LEE expressed reservations about the option of supplying the non-standard drugs at the hospital pharmacies as this might have additional resources implications on HA and create extra workload for HA staff. D(PS&O) responded that HA was open-minded on the arrangement for the supply of drugs which were to be purchased by patients at their own expenses and it would like to hear more views before determining the way forward.

25. Mr LI Kwok-ying said that since HA had pointed out that the introduction of the Formulary was not for the purpose of saving money and that the number of patients who had been put on drugs which belonged to the group described in paragraph 13(a) of the paper was very small, the cost implications incurred by including this group of drugs in the Formulary should not be too substantial. He considered that patients groups and social workers should be represented in the HA panel responsible for screening of drugs for inclusion in the Formulary.

26. CE/HA responded that drugs like Glivec had all along been outside existing drug formularies of HA hospitals. The current proposal actually aimed at devising a mechanism for introducing more drugs proven to be of significant benefits but extremely expensive, which the HA would otherwise not be able to introduce. He said that in formulating the framework of the Standard Drug Formulary, HA had set up expert panels comprising specialist clinicians, pharmacists and academics to screen and deliberate on the utilisation and indications of drugs for each clinical specialty. Patients groups were also consulted in the process and reference was made to overseas practices.

27. Mr LI Kwok-ying requested information on the number of unsuccessful

Action

Admin/HA applications for the Samaritan Fund to meet the costs of drugs. CE/HA agreed to provide the information later.

28. Mr Albert CHENG considered that with the introduction of the Standard Drug Formulary, patients in HA would be divided into two classes i.e. the rich and the poor. He said that patients who could afford expensive drugs would be given drugs with better efficacy and less side-effect. However, those who were poor would be given cheaper drugs which might present many side-effects. Mr CHENG pointed out that in fact, patients with chronic mental illness had been complaining that they were given drugs which presented such serious side-effects that their normal lives were also affected. Mr CHENG considered that before a long-term healthcare financing strategy was devised, the Administration should not require HA to introduce measures for reducing healthcare expenditures. He further asked whether the Administration was still planning to reduce HA's annual budget by 11% for the next three years.

29. DSHWF responded that given the overall large deficit of the Government, each service unit, including HA, had its duty to achieve savings and to make its operation more efficient and effective. As to HA's drug expenditure, there had been, on average, an annual increase of 8% over the past eight years and there would not be an anticipated reduction in drug expenditure in future. She added that HA had put in place mechanisms under which complaints about the adverse effect of drugs prescribed would be followed up.

30. Mrs Selina CHOW said that the concerns of the elderly patients were already clearly set out in the submission made by the Concern Alliance in the Interests of the Elderly (LC Paper No. CB(2)800/04-05(01)) and she suggested that the Administration or HA should address such concerns. She further said that the rationales and needs for the development of a Standard Drug Formulary were justified and the bone of contention was mainly the proposal in paragraph 13(a). She considered that HA should provide further information on the types of drugs which would fall within this group in order to allay the concern of patients groups and the community.

31. In response to Mrs CHOW, CE/HA reiterated that the large majority of patients would not be affected by the introduction of the Formulary because they were put on drugs which would be included in the Formulary. He pointed out that the number of drugs which fell within the group described in paragraph 13(a) was very small and they were mainly for treatment of cancer and had been introduced into the market only recently. He explained that as in the past, patients could use such drugs at their own costs or seek subsidy through the safety net mechanism.

32. Mrs CHOW asked through what channels that the elderly patients could find out whether the drugs they were taking would be included in the Formulary,

Action

D(PS&O) responded that patients could ask their doctors or make enquiries on the policy via the HA telephone hotline, by email or by fax.

33. Mr Vincent FANG also considered that there were justified needs for the development of a Standard Drug Formulary and he also believed that the Formulary would have only minimal impact on the elderly, the chronically ill patients and the poor. On the drug charging policy of HA, Mr FANG said that there was room for increases in drug fees and he believed that over 80% of people of the middle class were able to pay for or contribute to their drug charges. He further said that by increasing drug fees, more drugs could be introduced into the Formulary and at the same time, the Administration should also expand the safety net so that more people would be eligible for subsidies to meet drug expenses.

34. Dr YEUNG Sum said that he had been in support of HA's policy of providing equal treatment to patients irrespective of the differences in their financial positions. He felt that he would accept the Standard Drug Formulary if it was introduced for the sake of enhancing efficiency and accountability of the drug policy and utilisation in HA hospitals and clinics. However, he would oppose the Formulary if its introduction gave rise to a situation that patients were given different treatments because of their affordability. He further said that HA should not introduce new medical fees or increase existing fees of public healthcare services before the Administration had completed a review of healthcare financing and formulated a long-term strategy. He disagreed with Mr Vincent FANG that HA should increase its drug charges at this stage.

35. In response, DSHWF pointed out that as past experience had shown, it was very difficult to reach a consensus on the long-term healthcare financing strategy. She said that while the Administration was conducting an exercise to examine healthcare financing options and planning to work out some options at the end of 2005, it had to be recognised that public resources were finite while medical costs and demands were ever-increasing. On the introduction of the Standard Drug Formulary, DSHWF said that 99.9% of the drugs in existing drug formularies would be included in the future Formulary and they would continue to be provided within the standard fees and charges. She added that the number of drugs outside the Formulary would be very small.

36. Members agreed to hold a special meeting to receive views from patients groups. DSHWF informed members that the draft Standard Drug Formulary would be released by the end of February. She proposed that the special meeting be held after the release of the draft Formulary so that the discussions would be more fruitful. The Panel agreed that the Clerk would fix the date of the meeting in consultation with the Chairman and the Administration.

Action

II. Contracting out of work/services and public-private collaboration in the Hospital Authority
(LC Paper Nos. CB(2)746/04-05(02) & (03) and CB(2)770/04-05(01))

37. Mr WONG Kwok-hing said that he and some other Members had handled a complaint case lodged by a group of HA staff who would be affected by the latest Public-Private Partnership (PPP) project on food services being explored by HA. He said that the staff concerned might be required to transfer to new posts under this project. However, according to HA's human resources policy as set out in paragraph 12(e) of the Annex to the paper, the staff concerned would suffer a salary cut of about 10% to 20% three to five years after the transfer, in case the maximum pay point of the new post was less than their present salary.

38. Mr WONG further said that HA had already invested a lot of money in the cook-chill facilities and had recruited professionals including senior chefs, dietitians, etc. who were now providing very satisfactory food services for patients. He considered that the Administration and HA should provide detailed justifications for implementing the PPP project.

39. Dr Fernando CHEUNG expressed concern about the impact of the PPP project on service quality and asked what measures would be put in place to monitor the service standard and food quality. Being one of the Members who had handled the complaint case mentioned in paragraph 37 above, Dr CHEUNG said that the complainants had expressed grave concern about the impact of the project on them, if it was implemented. He added that staff morale would be adversely affected if HA failed to work out proper arrangements for the staff in taking forward the project.

40. DSHWF responded that as set out in the paper, HA had all along engaged outside contractors to undertake certain work/provide certain services that were related to the functions of the HA. She said that HA, like many other public sector organisations, had contracted out part of its non-core work/services, e.g. car park management. DSHWF further pointed out that HA was empowered under the Hospital Authority Ordinance to do all such things that were necessary for, or incidental or conducive to the better performance of its functions.

41. CE/HA said that the overriding concern of HA in launching any projects had always been patients' interests and how to make the best use of public resources. He stressed that HA would carefully and objectively compare the cost effectiveness of providing food services internally against the engagement of a private partner. He further said that the PPP project on food services would be implemented only if the project was able to achieve greater cost effectiveness and efficiency than the present mode of delivery. He said that the project would be piloted only in hospitals in the New Territories West and Kowloon Central Clusters, since some of the hospital kitchens in these clusters were rather run down,

Action

the kitchens of the hospitals concerned could be enhanced by requiring the prospective service provider to make the necessary investment under the project to improve the kitchen facilities.

42. CE/HA further said that the PPP project, if implemented, would not directly affect general grade staff e.g. Workmen, Foremen, Clerical Officers, of the catering department of the HA as they would be transferred to other departments of HA. He said that the only staff who would be directly affected would be Chefs and Cooks, but their number would be quite small. D(PS&O) said that HA would make appropriate arrangements for the affected Chefs and Cooks, who made up only about 10% of the staff establishment of the grade. Details of the arrangements were set out in paragraph 12 of the Annex to the paper. D(PS&O) added that HA would also continue to explore other feasible options with staff.

43. Mr WONG Kwok-hing said that given that the PPP project would have a great impact on the standard of HA's food services and the service period proposed was as long as 10 years, HA was obliged to provide more details of the project, such as the tendering conditions, cost savings that could be achieved and the service monitoring mechanism. Dr Fernando CHEUNG suggested that HA should provide a breakdown on the cost savings by sources of costs, such as administrative and management costs, staff costs, and food and production costs.

44. Dr Joseph LEE said that he supported the PPP project in principle provided that it could achieve greater cost effectiveness and maintain service quality. He considered that HA should provide information on the cost effectiveness, the service monitoring mechanism and whether clauses providing for early termination of contract would be included in the relevant contract. He also urged HA to maintain communication with relevant staff groups to address their concerns.

45. Ms LI Fung-ying suggested that the arrangement set out in paragraph 12(e) of the Annex to the paper should be reviewed in order to address the concern of the affected staff. DSHWF explained that HA would be putting in place a series of measures, as set out in paragraph 12(a) to (d) of the Annex to the paper, to take care of the affected staff. She pointed out that the arrangement in paragraph 12(e) would be adopted only as the last resort.

46. CE/HA said that HA attached great importance to staff morale and would maintain communication with staff in the remaining phases of the PPP project. He reiterated that only a very small number of Chefs and Cooks would be affected under the PPP project and those who were HA staff might opt for the Voluntary Early Retirement Programme and other mutually agreed arrangements.

47. CE/HA informed members that HA had put in place a stringent monitoring mechanism for its food services. HA would take into account patients' feedback

Action

in assessing the service standard and food quality under the PPP project. He said that the contract to be signed with the prospective service provider would also contain clauses to enable HA to terminate the contract early should it find the service unsatisfactory. In response to Mr LI Kwok-ying's question, CE/HA said that the service period was tentatively set at 10 years in view of the huge investment in facilities and infrastructure involved as well as the relatively long payback period. He explained that if the service period was to last for, say, only five years, the pricing would be much higher and this would defeat the original purpose of HA to implement the project.

48. In response to Dr Fernando CHEUNG, CE/HA said that until HA had completed vetting proposals from tenderers and the selection of the service contractor, it was not known at the present moment the cost savings that could be achieved. He added that HA would not go ahead with the PPP project unless cost savings could be achieved. DSHWF said that in vetting the proposals submitted by prospective service providers and in deciding whether to go ahead with the PPP project, HA would give due consideration to staff arrangements and patients' interests.

III. Health and health services research fund

(LC Paper No. CB(2)746/04-05(04))

49. Members expressed support for the Administration's proposal to increase the approved commitment for the Health and Health Services Research Fund by $16 million from $10 million to $26 million. Dr Joseph LEE requested information on whether the findings of any research items had influenced any practice or policy. The Chairman requested the Administration to provide the information when it submitted the paper to FC later.

Admin

50. There being no other business, the meeting ended at 10:50 am.

Council Business Division 2
Legislative Council Secretariat
12 April 2005