# *立法會*
# *Legislative Council*

LC Paper No. CB(2)2077/04-05

Ref : CB2/PL/HS

**Report of the Panel on Health Services**
**for submission to the Legislative Council**

## Purpose

This report gives an account of the work of the Panel on Health Services during the 2004-2005 Legislative Council (LegCo) session. It will be tabled at the Council meeting on 6 July 2005 in accordance with Rule 77(14) of the Rules of Procedure.

## The Panel

2. The Panel was formed by resolution of this Council on 8 July 1998 and as amended on 20 December 2000 and 9 October 2002 for the purpose of monitoring and examining Government policies and issues of public concern relating to health services matters.

3. The terms of reference of the Panel are in **Appendix I**.

4. The Panel comprises 13 members, with Hon Andrew CHENG Kar-foo and Dr Hon KWOK Ka-ki elected as Chairman and Deputy Chairman of the Panel respectively. The membership list of the Panel is in **Appendix II**.

## Major work

Proposed amendments to the Smoking (Public Health) Ordinance

5. The Administration consulted the Panel on its proposed amendments to the Smoking (Public Health) Ordinance at three meetings in early 2005.

6. Having regard to the views expressed by certain concern groups of the catering and hospitality industries, some members urged the Administration to conduct further consultation with the industries before finalising the proposals. The Administration assured members that the legislative intent and the

proposed legislative amendments would be clearly explained to the industries concerned, and consultation with them would continue before and after the Bill was introduced.

7. Some members suggested that the Administration should step up its public education on employees' right to a safe working environment under the Occupational Safety and Health Ordinance and include employees of the catering and hospitality industries in the consultation process. As there were many employers in support of the smoking ban and some had already made their premises smoke-free, the Administration should enlist their support of the proposed amendments.

8. The Panel was concerned about enforcement of the legislation and was sceptical whether the Tobacco Control Office (TCO) would have sufficient manpower to enforce the smoking ban in indoor workplaces and public places effectively. Some members suggested that other law enforcement agencies should assist in enforcement. Staff of other government departments, such as the Labour Department and the Food and Environmental Hygiene Department, should also be involved in the enforcement of the smoking ban during their inspection of the relevant indoor workplaces and public places. The Administration was also urged to consider introducing a fixed penalty system similar to that for littering offences.

9. The Administration informed members that the current establishment of TCO of about 30 staff would be doubled to enable it to carry out its duties effectively. Where necessary, manpower resources from the Police would be deployed to TCO to assist in its work. The Health, Welfare and Food Bureau (HWFB) would secure the support of the other bureaux as far as possible in the implementation of the smoking ban. HWFB would closely monitor the situation and seek additional funding where necessary.

Introduction of a Drug Formulary in the Hospital Authority

10. The Panel was briefed on the proposed Hospital Authority (HA)-wide Drug Formulary at its meeting on 31 January 2005. The main objective of developing a standardised 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. Following the initial discussion, the Panel held a special meeting on 8 March 2005 to receive views from patient groups and other organisations concerned.

11. While members had no objection in principle to the policy of standardisation of drugs in all HA hospitals, they expressed concern that the introduction of the Drug Formulary was perceived by many patient groups and members of the public as a cost saving measure to reduce public healthcare

expenditure. Some members were worried about the impact on patients, as all along, public hospitals had been providing the same medical treatment to patients suffering from the same illness regardless of their means. Although a safety net would be available, some might fail to meet the eligibility criteria for subsidy by a narrow margin and had to exhaust their lifelong savings to pay for the necessary drug charges. These members considered the proposal a fundamental change in public health policy.

12. Some members were of the view that since the Administration was in the process of taking forward a study on long-term healthcare strategies and financing options, it would be worthwhile for the Administration to consider deferring the introduction of the Drug Formulary and dealing with it in the context of its review on healthcare financing.

13. The Administration explained that at present, there were variations in practices across HA hospitals in relation to clinical use of certain new drugs and situations under which patients should purchase drugs at their own cost. As a result, patients with similar conditions could receive different drug therapies at different hospitals or could be required to pay for the cost of a drug at one hospital but not so at another. The proposed Drug Formulary was a measure to ensure equity and fairness in access to drugs of proven clinical efficacy and therapeutic effectiveness.

14. The Administration pointed out that the present draft Formulary included more than 1 200 types of drugs covering the majority of drugs required by patients and more than 60 types of them were for the treatment of cancer-related diseases. At present, some expensive drugs were already self-financed by patients. The Administration further explained that one important aspect of the Government's healthcare policy was that patients who could afford to pay should contribute to the drug expenses, while those in genuine hardship were given assistance under the targeted subsidy principle.

15. In response to members' concern about the administration of the safety net, the Administration assured members that it was mindful of the need to enhance the transparency of the system and would work with organisations in the social work sector to improve the system.

16. The Panel passed a motion at the meeting on 8 March 2005 urging that the cost of non-standard drugs proven to be of significant benefits but extremely expensive should be fully met by HA without any means testing of the patients, and that an appropriate fee reduction mechanism should be put in place for the benefits of patients receiving non-standard drugs which were outside any existing safety net protection.

17. The Administration reported to the Panel on 13 June 2005 the views collected in the three-month public consultation exercise which ended on 30 April 2005. As regards the concerns about the drugs in the Formulary, the Administration pointed out that as drugs for acute and chronic diseases (some being expensive drugs) were included in the Formulary and covered within the standard fees and charges, there would not be any significant impact on the chronically ill, elderly and underprivileged. HA would review the present assessment criteria for drugs under the Samaritan Fund. The affordability of applicants would be determined on the basis of disposable income (i.e. after deducting essential family expenditure from the household income and saving) and the required drug expenditure.

18. Members noted that the Administration would introduce the HA Drug Formulary by phases starting with the New Territories East Cluster in mid-July 2005, with other hospital clusters following in the ensuing months in order to minimise the impact on patients. Members requested the Administration to provide a paper on the safety net mechanism for discussion by the Panel in October 2005.

Continuing medical education for medical practitioners

19. The Panel discussed continuing medical education (CME) for medical practitioners, which was proposed by the Medical Council of Hong Kong (the Medical Council) to keep the profession abreast of new medical knowledge and technology, and ensure the provision of quality medical service to the public.

20. Members noted that in response to the Consultation Document on Health Care Reform published by the then Health and Welfare Bureau in December 2000, the Medical Council agreed with the Bureau's proposal that all doctors should be required to undertake CME to ensure that their knowledge, practice and skills were up to date. In 2001, the Medical Council decided that a voluntary CME scheme should be introduced first. A three-year voluntary CME programme for practising doctors who were not taking CME programme for specialists was launched on 1 October 2001. It was intended that CME requirements for medical practitioners would be made compulsory upon completion of the first voluntary CME cycle.

21. Members also noted that in order to encourage doctors' participation in the CME programme, doctors who had accumulated 30 or more CME points in a year would be awarded a CME Certificate to certify that they had achieved a satisfactory level of CME activity during a certain period. In addition, doctors who had accumulated 90 or more CME points during their three-year CME cycle would be allowed to use the title "CME-Certified" on their visiting cards.

22. To ensure compliance with mandatory CME, the Medical Council decided in March 2002 that compliance with the CME requirements should be linked with renewal of practising certificates. Professional medical organisations, including the Hong Kong Medical Association, Hong Kong Doctors Union, Practising Estate Doctors Association and the Association of Licentiates of Medical Council of Hong Kong, had written to the Administration expressing reservation and objection to the proposal of linking compliance with the CME requirement with renewal of practising certificates.

23. Some members considered that in view of the objection of some major professional medical organisations, the Administration should hold further discussions with the profession before deciding the way forward. Some other members were of the view that while CME was desirable and in the interest of the medical profession, a compulsory scheme might not be the best approach. In their view, doctors who did not undertake CME would ultimately suffer in terms of falling status and business. These members believed that patients should be able to make informed choices of their healthcare providers, if they could have easy access to the relevant information.

24. Some other members, on the other hand, expressed strong support for the proposed mandatory scheme and considered that it should be implemented immediately. These members noted that as of April 2005, only about half of the non-specialist doctors were engaged in CME. They pointed out that other professions, such as solicitors and accountants, already had a mandatory continuing education system in place. As medical practice involved human lives, there were all the more reasons to implement a mandatory CME scheme for medical practitioners as soon as possible.

25. The Administration was requested to provide more detailed information on studies on CME schemes in overseas jurisdictions, and the implementation details of the proposed mandatory CME scheme for further consideration by the Panel. The Administration was also asked to revert to the Panel on the progress of its consultation with the medical profession on the proposed mandatory CME scheme.

Development of Chinese medicine clinics in the public sector

26. The Panel was briefed in June 2005 on the Administration's way forward in the development of Chinese medicine clinics in the public sector.

27. The Administration explained that the objectives of providing Chinese medicine service in the public sector were to develop standards in Chinese medicine practice, to systematise the knowledge base of Chinese medicine through clinical research, and to provide training in "evidence-based" Chinese medicine.

28. The first phase of introducing Chinese medicine clinics in the public sector commenced in December 2003 with the establishment of three Chinese medicine clinics. The service had been provided on a tripartite model in which HA collaborated with a non-governmental organisation (NGO) and a university in each of the clinics. Each of the three clinics was attached to a hospital and patients were charged a fee of $120 per attendance. Following a review of the service provided in the three Chinese medicine clinics, the Administration decided to proceed with the development of Chinese medicine clinics in the public sector in phases. The next phase would probably involve the Wan Chai and Yuen Long districts, and possibly also West Kowloon.

29. Members referred to the Administration's plan to establish 18 Chinese medicine clinics in the districts and urged the Administration to implement the plan as soon as possible as to meet the need of elderly patients. The Administration explained that the main problem in setting up more clinics was the lack of suitable sites. In the case of Wan Chai and Yuen Long, the sites were already available. Given the efficiency made possible by the use of information technology, there was no need for the clinics to be attached to a hospital. They could therefore be more conveniently located for the benefits of the patients. The Administration would identify suitable sites in the other districts with a view to meeting its objective of setting up 18 Chinese medicine clinics as early as possible.

30. As to meeting the need of the elderly for Chinese medicine services, the Administration pointed out that the private sector was already providing generally comprehensive and affordable Chinese medicine services to the community and some NGOs had long been providing free Chinese medicine services in a number of districts. The Administration considered that the public sector should not seek to compete with the service providers in the private sector.

31. Members also expressed concern about provision of clinical training for Chinese medicine graduates. The Administration responded that in both service provision and training of new graduate, the public sector should not be the sole or major player. The private sector would also be encouraged to train new graduates of Chinese medicine, most of whom would practise in the private sector environment on completion of training.

Measures to address the increasing use of public medical services by non-residents of Hong Kong

32. At the meeting of the Panel on 13 December 2004, members' views were sought on a number of possible measures under consideration by the Administration to address the increasing use of public medical services by non-

residents of Hong Kong. The possible measures included raising the charges for such persons at public hospitals and clinics to above costs, introducing a minimum package charge for obstetric admissions, increasing the deposit for hospital admissions; and imposing a surcharge on outstanding fees.

33. Members agreed that it was necessary to address the problem of an increasing number of Mainland women coming to Hong Kong for childbirth and the bad debts arising from such cases. However, they expressed doubts about the effectiveness of the proposed measures and urged the Administration to explore other more effective measures, such as not to issue a birth certificate to the newborn, or forbidding a defaulter from leaving Hong Kong until the relevant medical charges had been settled. Other suggestions made by members included enlisting the assistance of the Mainland authorities in recovering the outstanding fees, and forbidding Mainland women in a late stage of pregnancy from entering Hong Kong unless they could produce proof of having made arrangements for admission to private hospitals in Hong Kong.

34. Members shared the view that it was necessary for HWFB to work together with the Security Bureau in tackling the problem. The Administration responded that it would carefully consider the legal implications of the suggested measures and provide a progress report on the Administration's deliberations.

35. At the Panel meeting on 17 May 2005, members' views were sought on a new proposed minimum package fee for non-eligible persons giving birth in public hospitals. While expressing support for the proposed introduction of a minimum package fee of $20,000 for obstetric services for such persons, members were doubtful whether it could reduce the number of non-eligible persons giving birth in Hong Kong. Some members were of the view that the proposed measure could lead to an increase in the number of cases of defaulting payment and worsen the bad debt situation.

36. Members considered that the situation of an increasing number of women coming to Hong Kong for childbirth should be controlled at source through joint efforts with the Mainland authorities. The Administration should also draw reference from other countries in considering appropriate measures to be adopted.

37. The Administration pointed out that following the relaxation of travel restrictions between the Mainland and Hong Kong, individuals could easily apply for a two-way permit to visit Hong Kong on paying a small fee. Some of the suggestions made by members were found to have practical and legal problems. Unless very stringent measures were introduced, it was very difficult to stop Mainland women coming to Hong Kong for childbirth. Nevertheless, the Administration was exploring the viability of amending the law to allow a

public officer to seek the court's agreement to issue a direction to the Director of Immigration to prevent a visitor who had yet to settle his/her medical fees with HA from re-entering Hong Kong. The Administration would report to members the viability of such option upon completion of its review.

Other matters discussed

38. Other subject matters discussed by the Panel included the Centre for Health Protection's objectives and strategies for 2004-2006, the Government's response to HIV/AIDS, remuneration of HA staff, progress of registration of Chinese medicine practitioners, comprehensive plan of action to deal with the global problem of avian influenza, separation of medical practice from prescription of drugs, abuse of cough preparations containing codeine and waiting time for consultation at General Outpatient Clinics.

39. The Panel was consulted on the Administration's proposed grant of $200 million to the Samaritan Fund, preparedness plan for influenza pandemic, proposed amendments to the Dentists Registration Ordinance and two public works items to improve facilities in the Specialist Outpatient Block of Pamela Youde Nethersole Eastern Hospital and infection control provisions in autopsy facilities.

40. From October 2004 to June 2005, the Panel held a total of 16 meetings, one of which was a joint meeting with the Panel on Food Safety and Environmental Hygiene.

Council Business Division 2
Legislative Council Secretariat
27 June 2005

**Appendix I**

## Panel on Health Services

## Terms of Reference

1. To monitor and examine Government policies and issues of public concern relating to medical and health services.

2. To provide a forum for the exchange and dissemination of views on the above policy matters.

3. To receive briefings and to formulate views on any major legislative or financial proposals in respect of the above policy areas prior to their formal introduction to the Council or Finance Committee.

4. To monitor and examine, to the extent it considers necessary, the above policy matters referred to it by a member of the Panel or by the House Committee.

5. To make reports to the Council or to the House Committee as required by the Rules of Procedure.

**Appendix II**

**Panel on Health Services**

**Membership list for 2004 - 2005 session**

| | |
|---|---|
| **Chairman** | Hon Andrew CHENG Kar-foo |
| **Deputy Chairman** | Dr Hon KWOK Ka-ki |
| **Members** | Hon Albert HO Chun-yan |
| | Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP |
| | Hon CHAN Yuen-han, JP |
| | Hon Bernard CHAN, JP |
| | Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, 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 |
| | (Total : 13 Members) |
| **Clerk** | Ms Doris CHAN |
| **Legal adviser** | Miss Monna LAI |
| **Date** | 12 October 2004 |