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Legislative Council

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LC Paper No. CB(2)1790/06-07
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting held on Monday, 2 April 2007, at 8:30 am in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, JP (Chairman) Dr Hon KWOK Ka-ki (Deputy Chairman) Hon Fred LI Wah-ming, JP Hon CHAN Yuen-han, JP Dr Hon YEUNG Sum Hon Andrew CHENG Kar-foo Hon LI Fung-ying, BBS, JP Hon Audrey EU Yuet-mee, SC, JP Hon Vincent FANG Kang, JP Dr Hon Fernando CHEUNG Chiu-hung
Members absent	:	Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP Hon Bernard CHAN, GBS, JP Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP Hon LI Kwok-ying, MH, JP
Public Officers attending	:	Items II and III Mr Patrick NIP, JP Deputy Secretary for Health, Welfare and Food (Health) 1 Ms Ernestina WONG Principal Assistant Secretary for Health, Welfare and Food (Health) 2 Mr Shane SOLOMON Chief Executive Hospital Authority

		Item II only Dr C C LUK Cluster Chief Executive (Kowloon East Cluster) Hospital Authority Item III only Ms Nancy TSE Director (Finance) Hospital Authority
Clerk in attendance	**:**	Miss Mary SO Chief Council Secretary (2)5
Staff in attendance	**:**	Ms Amy YU Senior Council Secretary (2)3 Ms Sandy HAU Legislative Assistant (2)5

Action

I. Items for discussion at the next meeting
(LC Paper Nos. CB(2)1454/06-07(01) and (02))

Members agreed to discuss the following items proposed by the Administration at the next regular meeting to be held on 14 May 2007 at 8:30 am -

(a) Progress report on registration of Chinese medicine practitioners;

(b) Development of Chinese medicine clinics in the public sector; and

(c) Monitoring the effectiveness of the measures taken by the Hospital Authority to address the increased demand for obstetric services in public hospitals by Mainland women.

(*Post-meeting note:* With the concurrence of the Chairman, item (c) above was discussed at the special meeting on 16 April 2007 under the agenda item "Effectiveness of the Hospital Authority's new obstetric arrangements and the

Action

obstetric service charge for non-eligible persons whose spouses are Hong Kong residents".)

II. Rationalisation of public hospital services
(LC Paper Nos. CB(2)1454/06-07(03) to (05), CB(2)1460/06-07(01) to (02) and CB(2) 1483/06-07(01))

2. Chief Executive, Hospital Authority (CE, HA) briefed members on the rationalisation of public hospital services, details of which were set out in the Administration's paper (LC Paper No. CB(2)1454/06-07(03)).

3. Dr YEUNG Sum expressed concern about the closing down of 38 convalescent beds in the Tseung Kwan O Hospital (TKOH) in the Kowloon East (KE) cluster when the bed-to-population ratio of KE cluster lagged far behind the average bed-to-population ratio in six other hospital clusters, i.e. 2.2 beds versus 3.8 beds per 1 000 population, as pointed out in the submission from the Sai Kung District Council (SKDC) (LC Paper No. CB(2) 1460/06-07(02)). Dr KWOK Ka-ki echoed similar concern.

4. CE, HA responded that to better enhance the role of TKOH as an acute hospital and having regard to the consistent reduction of length of stay at the Haven of Hope Hospital (HHH) in the same district in recent years due to improvements in rehabilitation techniques, decision was therefore made to close down 38 convalescent beds in TKOH and converge convalescent service under HHH. CE, HA agreed that more beds should be provided in KE cluster to better meet patients' demand. To this end, HA was presently looking at ways on how best to utilise the space freed up by the 38 convalescent beds in TKOH. One of the options being considered was to turn the vacated ward into day ward, having regard to the fact that some 90% of surgeries nowadays could be performed on a day basis due to improvements in surgical techniques. CE, HA further said that to ensure that patients' interests would not be undermined as a result of the re-structuring of services of TKOH and concentration of convalescent service under HHH, complementary measures would be adopted to tie in with the new arrangements, which included enhancement of non-emergency ambulance service for convalescent patients and rationalisation of the delivery process of various hospital services.

5. Mr Vincent FANG queried whether the re-organisation of services in KE cluster, through replacing in-patient services with ambulatory and community care, was a ploy to save money. Mr FANG said that he had no strong view against such a shift so long as care to patients was not compromised.

6. CE, HA responded that the re-organisation of services in KE cluster was aimed at achieving better utilisation of resources so that more patients could be

Action

treated and waiting time for treatment could be reduced. HA was presently developing a new service model for TKOH. Not only would there be no reduction in manpower, additional nurses would be recruited to support the future provision of services and expansion plans for TKOH as well as HHH. Cluster CE (KE cluster) supplemented that additional resources would be allocated to KE cluster to implement the expansion plans for TKOH and HHH in due course.

7. Deputy Secretary for Health, Welfare and Food (Health) 1 (DSHWF(H)1) assured members that although international trend had been to focus on the development of ambulatory and community care programmes to reduce reliance on in-patient care, Hong Kong would not likely take forward such a trend in public hospitals without first making reference to overseas and local experience and consulting all stakeholders.

8. Ms LI Fung-ying said that although re-deploying resources among hospitals under a cluster to achieve better utilisation of resources was worthy of support, convenience to patients should not be compromised as a result. Ms LI enquired about the criteria adopted in the rationalisation of public hospital services, and whether patients' convenience was one of the factors in considering re-organisation of services.

9. DSHWF(H)1 responded that the design of the clustering arrangements of public hospitals was aimed at providing timely acute and emergency services together with other medical services, including rehabilitation or community-based services, to people living in the area covered by a particular cluster. Under the existing clustering arrangements, each hospital cluster comprised a number of acute and convalescence/rehabilitation hospitals and institutions, providing a full range of comprehensive health care services to meet the health care needs of the community. Hospitals were grouped into clusters based on the best match of portfolios of public hospitals in a geographical region in terms of role delineation and service provision, the utilisation pattern of hospital services in the region as well as the demographic structure of the region. Close monitoring of the adequacy and quality of services to patients was continuously being carried out by all hospital clusters, and rationalisation of services would be made having regard to demographic changes and increase in service demand and service utilisation with the area, while mapping out plans for the provision of facilities and services in the future.

10. DSHWF(H)1 further said that although providing patients with convenient access to health care services was certainly one of the objectives in hospital clustering, it was necessary for certain specialised services to be centralised in a few hospitals to secure the necessary critical mass of workload to sustain quality outcomes and to ensure value for money for patients. Although this might cause some inconvenience to patients, from the medical point of view, with the concentration of expertise, technology and facilities, the

Action

centralisation of certain specialised services in a few centres would enable the hospitals to provide higher quality medical care to patients. CE, HA supplemented that patients could receive care in hospitals other than those in their own residential districts. It was fairly common that some patients would choose to seek treatment from other clusters.

11. Dr KWOK Ka-ki criticised that HA should not rely on patients to seek treatment from other clusters. In response, CE, HA said that it was not possible for each cluster to achieve 100% self-sufficiency for the reasons already given by DSHWF(H)1 in paragraph 10 above. Even the Hong Kong West cluster, which was best provided, did not have 100% self-sufficiency. A more realistic aim was to achieve a fairly high level of self-sufficiency within a cluster, as some patients preferred to seek treatment from other clusters.

12. Mr Fred LI said that as the reason for setting up TKOH was to reduce the heavy workload of the United Christian Hospital in the same cluster, it was unreasonable to close down 38 convalescent beds at TKOH when the cluster already had the lowest bed-to-population among the seven hospital clusters and that TKO and SK districts had a large population of older persons with low income. Mr LI further asked the following questions -

(a) whether there was any plan to reduce up to 75 beds in TKOH, including closing down a surgery ward, as pointed out by SKDC in its submission; and

(b) whether there would be no increase in the number of convalescent beds in HHH as a result of the implementation of the re-organisation plan.

13. Cluster CE (KE cluster) responded in the negative to Mr LI's first question. He further said that implementation of the re-organisation plan would not affect the relevant medical services in TKO district, nor would it affect the future provisions of services and the expansion plans for TKOH and HHH. In order to provide more convenience to people residing in TKO district, KE cluster planned to improve day surgery and treatment services as well as out-patient service at TKOH. As regards Mr LI's second question, Cluster CE (KE cluster) said that HHH would re-deploy internally to provide an additional 38 convalescent beds to support TKOH's convalescent service.

14. Mr Andrew CHENG said that the Administration should not cut public medical services when it had considerable surplus. Mr CHENG queried whether HA had consulted with SKDC and TKOH Governing Committee prior to the closing down of the 38 convalescent beds. Dr Fernando CHEUNG raised similar query.

Action

15. DSHWF(H)1 stressed that it was re-deployment, and not reduction, of convalescent beds in KE cluster, the objective of which was to achieve better utilisation of resources. DSHWF(H)1 further said that HA had been communicating closely with SKDC and other local organisations on the re-organisation of KE cluster. HA would continue to maintain active dialogue with SKDC and would brief members of SKDC on the re-organisation plan of KE cluster.

16. Miss CHAN Yuen-han opined that HA should not downplay the importance of number of beds in the provision of medical services in a cluster.

17. DSHWF(H)1 responded that there was no question of the situation mentioned by Miss CHAN Yuen-han in paragraph 16 above. Although bed-to-population was one of the planning parameters adopted by HA in the provision of medical services, it should be pointed out that advances in medical technology and development in ambulatory and community care had made it possible for patients to be discharged with shorter stay in hospitals.

18. Mr Vincent FANG enquired whether, apart from KE cluster, HA had plans to rationalise services in other hospital clusters.

19. CE, HA responded that HA had no plan to rationalise services in other hospital clusters at this stage, albeit it was constantly looking into ways to make the best use of resources having regard to changes in demand and service development. CE, HA however pointed out that some re-structuring of hospital services might be necessitated by measures to reduce the long working hours of doctors.

20. Mr Vincent FANG was of the view that the Administration should increase its funding allocation to HA, having regard to the Government's much improved financial position following the strong recovery of Hong Kong's economy. Miss CHAN Yuen-han and Dr YEUNG Sum expressed similar views.

21. DSHWF(H)1 responded that in 2007-2008, the Government’s appropriation to HA was estimated at $28.6 billion, an increase of more than $670 million or 2.4% compared with that of last year. The $670 million increase mainly came from an allocation of additional recurrent funds of $295 million as pledged in last year’s Budget Speech that there would be an annual increase of subvention to HA of some $300 million per annum over the next three years. Besides, an allocation of about $390 million for procurement of medical equipment and information technology systems also constituted part of the increase. DSHWF(H)1 however pointed out that in view of an ageing population, rising patients' expectation and given that resources were finite, there was a need to come up with feasible health care financing options to sustain the public health care system in the long term.

Action

22. Responding to Dr KWOK Ka-ki's enquiry on whether the additional provision to HA would be mainly spent on covering pay increase for HA staff, CE, HA said that the new provision would mainly be used on strengthening existing measures and introducing new initiatives to improve the quality of health care services. While it was expected that there would be a small increase in the number of promotion this year, the budget did not cater for an overall pay increase which was a matter still awaiting the results of the pay level survey being conducted by the Government.

23. Mr Vincent FANG said that in view of the increasing number of doctors leaving HA in recent years, it was necessary for the Administration to further increase funding to HA to retain experienced doctors.

24. CE, HA responded that the wastage rate of doctors in the past two years was around 6.5%, which could be attributed to expansion in the private sector on the one hand and lack of pay rise and promotion prospect in HA on the other hand. Fortunately, 320 new doctors would be joining HA this year, which should be sufficient to replace the doctors leaving. Notwithstanding, HA would closely monitor the wastage rate of doctors to ensure that experienced doctors could be retained as far as practicable.

25. The Chairman asked whether funding to HA was based on the population in a cluster. DSHWF(H)1 replied in the positive, and further pointed out that the effective population in a cluster was not necessarily the same as the population living in that cluster. It took into account the inter-cluster flow of patients due to factors such as patient preferences, location of a patient's work place and distribution of specialised services in different clusters. DSHWF(H)1 further said that the Administration would be in discussion with HA on whether the existing funding mechanism to HA was still valid to ensure long term sustainability.

26. As future increase in population would likely be concentrated in newly developed areas such as the Northern District and Tin Shui Wai, Dr YEUNG Sum asked whether HA had taken this factor into consideration in its allocation of resources among the seven hospital clusters. Dr KWOK Ka-ki raised a similar question, having regard to the disproportionately less resources provided to KE and the New Territories West (NTW) clusters as compared with other clusters.

27. CE, HA responded that additional Government funding to HA would in the main be directed to those geographical areas undersupplied in medical services. For instance, some $150 million had been earmarked for NTW cluster in 2007-2008 to tie in with the opening of the redeveloped Pok Oi Hospital and the Rehabilitation Block of the Tuen Mun Hospital, which would include the deployment of an additional 130 nurses and 62 doctors. As

Action

mentioned earlier at the meeting, additional resources would be allocated to KE cluster once the expansion plans for TKOH and HHH had been drawn up. CE, HA further said that although additional funds would be provided to these two clusters this year, more time was needed to raise their provisions to levels comparable to other clusters.

Conclusion

28. Dr KWOK Ka-ki proposed to move the following motion -

"本委員會促請政府及醫管局正視及改善不同醫院聯網之間資源分配不均的情況，並

(一) 停止關閉將軍澳醫院 38 張康復病床；及

(二) 增撥資源予人手及資源嚴重不足的聯網，包括人手及病床嚴重不足的新界西及九龍東聯網。"

(Translation)

"That this Panel urges the Government and HA to face squarely and improve the uneven distribution of resources among different hospital clusters, and also

(a) cease to close down 38 convalescent beds in TKOH; and

(b) allocate more resources to those clusters facing serious shortage of manpower and resources, including NTW and KE clusters which are suffering serious shortage of manpower and hospital beds."

29. The Chairman put Dr KWOK's motion to vote. Seven members voted in favour of the motion, no member voted against it, and one abstained. The Chairman declared that Dr KWOK's motion was carried.

30. Mr Vincent FANG proposed to move the following motion -

"本委員會促請政府在現時財政充裕的情況下，增加對醫管局的撥款。"

(Translation)

"That this Panel urges the Government, in view of its existing strong financial position, to increase funding allocation to HA."

Action

31. The Chairman put Mr FANG's motion to vote. All members present at the meeting voted in favour of the motion. The Chairman declared that Mr FANG's motion was carried.

Admin

32. The Chairman called on the Administration and HA to give due consideration to the two motions passed by the Panel. The Administration was also requested to provide the following information after the meeting -

(a) bed-to-population ratio; health care professional-to-population ratio; funding allocation for 2007-2008; utilisation rates of various hospital services and their associated median waiting time; and types and capacities of ambulatory and community care services provided to day patients, in each of the seven hospital clusters;

(b) re-organisation of services undertaken in the past and its impact, if any, on the districts served; and

(c) cross-cluster utilisation of hospital services in the past three years.

III. Private patient services at public hospitals and fee-sharing arrangements

(LC Paper Nos. CB(2)1454/06-07(06) and (07))

33. DSHWF(H)1 briefed members on the private patient services provided at public hospitals and fee sharing arrangements, details of which were set out in the Administration's paper (LC Paper No. CB(2)1454/06-07(06)).

34. The Chairman informed members that Dr KWOK Ka-ki had earlier written to him requesting to invite representatives from the University of Hong Kong (HKU) to attend this meeting. As the issue of how HKU used the income earned from private patient services at public hospitals was outside the scope of the discussion of the meeting, he had not acceded to the request.

35. Members noted a submission from HKU entitled "Background information on HKU's income from providing services to private patients" tabled at the meeting (LC Paper No. CB(2) 1483/06-07(02)).

36. Dr YEUNG Sum declared that he was a teaching staff of HKU. Dr YEUNG said that he was in support of the provision of private patients services at public hospitals by the teaching staff from HKU and the Chinese University of Hong Kong (CUHK), as it helped to enhance the expertise of the teaching staff, facilitate patient's choice and shorten waiting time for treatment, apart from providing specialised services which were not generally available in

Action

the private sector. Dr YEUNG further sought the following information from HA -

(a) whether it had received any complaint concerning the charging of patient fees and charges for private patient services provided by the teaching staff from HKU and CUHK;

(b) whether income earned from private patient services by the two universities was used solely on supporting academic research and other professional development purposes; and

(c) whether there was any way to ensure that teaching staff from the two universities would not waive fees and charges of private patient services, in full or partially, for their friends and relatives.

37. CE, HA responded that HA had not received any complaint in the past concerning the charging of patient fees and charges for private patient services provided by teaching staff from HKU and CUHK, with the exception of the recent case of irregular billing of private patients treated by teaching staff from HKU which had been referred to the relevant law enforcement authority for investigation. CE, HA further said that HA had no authority over the use of income earned by the two universities from private patient services nor did HA have any knowledge on how such income was used. CE, HA however pointed out that HA had clear policies and guidelines on the billing of private patient services. The fact that the core billing system of HA, i.e. the Patient Billing and Revenue Collection system, could detect the recent case of irregular billing of private patients was a testament that the billing system was working well. Nevertheless, HA was currently conducting a review of the internal controls of the private patient fee billing system to identify area of improvement in order to minimise the risk of any potential abuse in future and ensure that procedures that were done in the operating theatre were reflected in the bill.

38. Mr Andrew CHENG asked the following questions -

(a) whether, and if so, what mechanism was in place to ensure that public medical services would not be compromised at the expense of providing private patient services at public hospitals, having regard to the rise in the number of private in-patient (IP) and specialist out-patient (SOP) attendance during the past three years as set out in paragraphs 6 and 8 of the Administration's paper; and

(b) whether, and if so, what mechanism was in place to ensure that income generated from private patient services was spent on improving the services of public hospitals, having regard to the substantial income generated from private patient services for the

Action

past five years as set out in paragraph 15 of the Administration's paper.

Dr KWOK Ka-ki raised similar queries.

39. Responding to Mr CHENG's first question, DSHWF(H)1 said that to ensure that public services would not be adversely affected by the provision of private patient services, there were guidelines in place at public hospitals that restricted the time each doctor could devote to private patient services to one consultation session a week (i.e. three to four hours). Similar guidelines were in place in HKU and CUHK restricting the time that each teaching staff of the Faculties of Medicine could provide private patient services. There was also agreement between the Government and HA that the total number of private beds in public hospitals should be limited to a maximum of 379 beds only. DSHWF(H)1 further said that private patient services only accounted for a small part of the overall services provided at HA. In 2005-2006, private SOP attendances accounted for only 0.47% of the total SOP attendances at public hospitals, while private bed-days accounted for only 0.62% of the total bed-days utilised.

40. Regarding Mr CHENG's second question, CE, HA said that HA retained 25% of the gazetted schedule of fees and charges paid by private patients regardless of whether teaching staff from the two universities decided to use their discretion to waive all or part of the remaining percentage of such fees and charges.

41. The Chairman asked whether teaching staff from the Faculties of Medicine of the universities had to notify HA if they decided to waive the fees and charges of their private patients to facilitate billing by HA. CE, HA replied that this was the case.

42. Dr KWOK Ka-ki asked whether it was true, as reported in some newspapers, that some private patients were given two separate bills payable to different accounts.

43. CE, HA responded that HA only sent one bill to each private patient on behalf of HA and the university concerned and the university would be reimbursed its share of the bill after collection of the fees.

44. Ms LI Fung-ying and Dr Fernando CHEUNG asked whether the existing billing system could ensure that all private patient fees were properly recorded, charged and audited; and if not, what improvement measures would be taken to address such.

45. CE, HA referred members to paragraphs 16 to 18 of the Administration's paper which set out the fee collection and monitoring mechanism adopted by

Action

HA in ensuring that all fees to be receivable by HA were properly recorded, charged and audited.

46. The Chairman said that the fee collection mechanism of HA still could not prevent teaching staff from the two universities from not charging their private patients.

47. CE, HA responded that as the billing system was not fully automated, it was inevitable that the system still relied on doctors to record the procedures they would perform on their private patients into the billing system. Director (Finance), HA supplemented that the manual part of the billing system related to the recording of itemised charges, such as operating theatres procedures, diagnostic and therapeutic/operative procedures, for private patients. Teaching staff of the two universities were required to fill in a form prescribed by HA as to what procedures/tests they would perform on their private patients. Upon receipt of such information, HA would input it into its billing system for preparation of bills to the private patients.

48. Dr YEUNG Sum said that while members respected the autonomy of universities in managing their internal affairs and finance, it was in the public interest to ensure that private patient fees received by HKU and CUHK were properly recorded, charged and audited. In the light of this, Dr YEUNG requested HA to discuss with the two universities on ways to achieve such for incorporating into its billing system and revert to the Panel, say, in two months' time. Dr KWOK Ka-ki and Miss CHAN Yuen-han expressed support.

HA/Admin

49. CE, HA responded that the review of the internal controls of the private patient billing system of the two teaching hospitals was expected to complete in three months' time. HA would be happy to report the results of the review to the Panel when they became available.

50. In closing, the Chairman said that the Panel on Health Services was not the appropriate forum for discussing the issue of how HKU and CUHK used the income earned from private patient services at public hospitals. Members who wished to do so might consider raising the matter at the Panel on Education. Where necessary, a joint meeting between this Panel and the Panel on Education could be held.

51. There being no other business, the meeting ended at 11:08 am.

Council Business Division 2
Legislative Council Secretariat
10 May 2007