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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 2006-2007 Legislative Council (LegCo) session. It will be tabled at the Council meeting on 4 July 2007 in accordance with Rule 77(14) of the Rules of Procedure.

The Panel

2. The Panel was formed by resolution of the 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 14 members, with Dr Hon Joseph LEE Kok-long 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

Registration of Chinese medicine practitioners

5. The Panel held two meetings with the Administration to discuss the new arrangements to assist listed Chinese medicine practitioners (CMPs) to pass the CMP Licensing Examination in order to obtain registration status. These new

arrangements included allowing the candidates to retain a pass in Paper 1 or Paper 2 of the written examination taken in or after 2007 for three years and to choose to re-sit the other paper; simplifying the question form of the written examination into single-choice question; and regrouping the 20 subjects of the written examination into 13 subjects.

6. Hon CHAN Yuen-han and Hon LI Fung-ying considered that merely revising the format and arrangement of the Licensing Examination would not help listed CMPs to become registered CMPs, as the problem with the inability of listed CMPs in obtaining registration status and with some of them not having applied to sit the Licensing Examination lay in the handling of the registration system for CMPs by the Chinese Medicine Practitioners Board of the Chinese Medicine Council of Hong Kong (the Practitioners Board) and in certain provisions of the Chinese Medicine Ordinance (Cap. 549) (CMO).

7. The Administration did not see the need to review the existing arrangements for registration of CMPs, which were the result of extensive consultation with different sectors of the community, the CMP profession and LegCo prior to the enactment of the CMO. All practising CMPs who wished to be registered might obtain registration status in the long run with the training provided by the Department of Health (DH) and local Chinese medicine organisations on examination skills, the efforts of listed CMPs and the continuous exchanges between the Practitioners Board and the CMP professionals about the Licensing Examination. To better help listed CMPs to prepare for the Licensing Examination, consideration could be given to including in the training course on examination skills organised by DH the frequent mistakes made by candidates. Notwithstanding, viable means would continue to be explored to assist listed CMPs who wished to become registered CMPs to obtain registration status.

8. Members did not see the justification for not allowing graduates of part-time degree courses in Chinese medicine to undertake the Licensing Examination, if the curriculum and standard of these part-time courses were no different from those of the full-time courses in Chinese medicine. They pointed out that many professions, such as lawyer and accountant, recognised the academic qualifications attained through distance learning or part-time programmes.

9. The Administration explained that as the practice of CMPs was closely related to the health of the public, the Practitioners Board considered that to complete satisfactorily an undergraduate course in Chinese medicine, students should have received comprehensive and fundamental university education and engaged in full-time study. Students should also be provided with adequate opportunity to practise continuously in order to complete all the relevant clinical

training and experiments. A full-time on campus learning environment was an important component of quality teaching. To maintain the professional standard and status of CMPs, and with regard to the corresponding licensing requirements for other healthcare professionals, such as medical practitioners and dentists, the Practitioners Board considered that the full-time mode of education should be adopted for the recognised courses for the CMP Licensing Examination.

10. Members noted that students enrolled in part-time undergraduate degree courses in Chinese medicine offered by the University of Hong Kong (HKU) and the Hong Kong Baptist University (HKBU) in or before 2002 were allowed to sit the CMP Licensing Examination when they had satisfactorily completed the courses by the Practitioners Board. Members asked why such arrangement was not extended to other part-time undergraduate degree courses in Chinese medicine offered by other local universities or jointly with non-local universities.

11. The Administration explained that this was because the part-time undergraduate degree courses in Chinese medicine offered by HKU and HKBU fulfilled the requirements of a recognised course, whereas this was not the case for other part-time undergraduate degree courses. The Administration, however, pointed out that to allow students enrolled in part-time undergraduate degree courses in Chinese medicine offered by HKU and HKBU in or before 2002 to sit the CMP Licensing Examination was an exceptional and one-off arrangement, in view of the historical circumstances of Chinese medicine education in Hong Kong universities.

12. To resolve the disputes about the eligibility for undertaking the CMP Licensing Examination, members urged the Administration to expeditiously convene a meeting between the Chinese Medicine Council of Hong Kong and institutes whose Chinese medicine degree courses were not recognised by the Practitioners Board and to invite Panel members to attend the meeting.

Development of Chinese medicine clinics in the public sector

13. The Panel was consulted in May 2007 on the Administration's plan to seek funding support for five additional Chinese medicine clinics (CMCs) in the public sector. It was the Administration's intention to start works in July 2007 for completion by phases before March 2009. Upon completion of the proposed works, the total number of CMCs in the public sector would increase to 14.

14. Members considered that even though there would be a total of 14 such clinics after the establishment of the five additional ones, the pace of introducing Chinese medicine service in the public sector was too slow and fell short of the Administration's target of setting up 18 CMCs by 2005-2006 as originally pledged.

Members pointed out that the slow pace of development of Chinese medicine was not conducive to providing sufficient clinical training grounds for Chinese medicine graduates, having regard to the fact that local universities offering Chinese medicine degree course were producing some 60 graduates each year.

15. The Administration explained that as the adoption of a tripartite model in which the Hospital Authority (HA) collaborated with a non-governmental organisation (NGO) and a local university in each of the CMCs was new, it was necessary to ensure proper development and testing of this new service delivery model by taking a phased approach. The Administration would strive to identify suitable sites for setting up the remaining four planned CMCs. The criteria for selecting CMC sites included accessibility, proximity to residential areas and timing of availability of the sites for conversion works. Other considerations included whether the clinics would be able to attract sufficient number of patients to sustain themselves financially and their impact on the private Chinese medicine practice in the vicinity.

16. In order to provide better training opportunities for graduates of Chinese medicine in local universities, the Administration advised that each NGO partner of CMC was required to engage and provide training for at least five graduates. Apart from this, the private sector had been encouraged to train new graduates as most of the latter would practise in the private sector environment on completion of training.

17. As to allowing recipients of Comprehensive Social Security Assistance (CSSA) to enjoy free Chinese medicine services at public CMCs, the Administration did not see a need for such at this stage. First, the NGO operating the CMC was at liberty to waive fees and charges in full or in part above the 20% quota to CSSA recipients as well as patients with financial difficulty where practicable. Second, apart from public CMCs, there were other CMCs operated by charitable organisations in the community offering free Chinese medicine services to the public. Notwithstanding, the Administration would closely monitor the adequacy of the provision of Chinese medicine services to needy patients.

18. The Administration also pointed out that Government's provision of fee waiver to CSSA recipients patronising CMCs would not reduce the fee charged by CMCs, as the fee was set based on factors, such as the operating costs of the clinics which to some extent were shared between the Government and the clinics and the level of charge in the private sector. If CSSA recipients were entitled to enjoy free medical services at CMCs with no quota set at CMCs, the patient base would be too narrow for the clinics to offer a wide range of exposure to Chinese medicine graduates and a wide spectrum of medical conditions for research purposes.

Regulation of health maintenance organisations

19. Members were briefed by the Administration in March 2007 on the progress made by DH's Working Group on Regulation of Health Maintenance Organisations in taking forward the medical director concept, which included spelling out the duties of the medical director and working with the Medical Council of Hong Kong on how medical directors could be incorporated into the Council's Professional Code and Conduct. To complement the Code of the Medical Council, DH was prepared to draw up guidelines to cover those extra requirements for medical directors which would not fall under the purview of the Medical Council. DH would also maintain a list of group practices that had appointed medical directors. If a medical director infringed the relevant codes of the Medical Council, he/she might no longer be eligible to perform the duties of a medical director and the respective group would be de-listed unless it appointed another eligible doctor as medical director. If the management of the group repeatedly and unduly interfered with the professional decisions of the medical director, the group would not be allowed to be listed again.

20. Members did not oppose the medical director concept per se, but considered that its implementation alone would be far from adequate in safeguarding patients' interests. A deputation representing the dental sector was of the view that the medical director should best be appointed by an independent body comprising of the stakeholders concerned.

21. The Panel met with deputations in June 2007 to listen to their views on the medical director concept. Deputations from the medical sector considered that the medical director concept was unable to safeguard patients' interests and urged for expeditious introduction of a licensing system; one deputation from a group practice considered it more effective to rely on market force to make HMOs practise in a responsible and ethical manner. The Consumer Council did not refute the medical director concept, but considered that the appointment of medical director should be made mandatory. In view of the conflict of roles of the medical director, the Consumer Council considered it necessary to put in a place a licensing system in the long run.

22. The Administration explained that the medical director concept was an effective first step to better safeguard patients' interests, as the medical directors, being doctors themselves, would also be subject to regulation by the Medical Council. The Administration had not ruled out the option of enacting legislation to regulate HMOs. However, given the myriad relationship among different parties involved in the delivery of healthcare services provided by HMOs, more time was needed to find out which party in the chain should be held accountable and which aspect of the whole operation should be regulated before determining how they

should be regulated. Most members maintained the view that HMOs should be regulated through a licensing system. The Administration was requested to provide the Panel with a timetable on regulating HMOs.

Impact of HA's new obstetric service charge for non-eligible persons whose spouses were Hong Kong residents

23. To address the increasing use of obstetric services by Mainland women which exerted heavy pressure on the obstetric services in the public hospitals and deprived local expectant mothers from accessing such services, HA introduced an Obstetric Package Charge for Non-eligible Persons (NEPs) at a rate of $20,000 for a stay of three days and two nights in all public hospitals on 1 September 2005. To better channel demand from Mainland women for obstetric services to the private sector, the NEP Obstetric Package Charge was revised to $39,000 for persons with a booking and $48,000 for those without one on 1 February 2007. A central booking system for obstetric services was also put into operation in all public hospitals by HA on the same date to enable it to better assess the demand for obstetric services and plan service expansion.

24. The Administration reported to the Panel in April 2007 that the new obstetric service arrangements for NEPs had been effective in -

(a) limiting the number of births by non-local pregnant women to a level that could be supported by the healthcare system;

(b) reducing non-local pregnant women seeking emergency hospital admissions through the Accident and Emergency Departments before labour;

(c) ensuring that local pregnant women would be provided with proper obstetric services and priority to such services in public hospitals; and

(d) reducing default payment by NEP pregnant women, as the full NEP Obstetric Package Charge was required to be paid at the time of booking.

25. Dr Hon YEUNG Sum, Hon Audrey EU, Hon LEE Cheuk-yan, Dr Hon Fernando CHEUNG, Dr Hon KWOK Ka-ki and Hon Fred LI were of the view that HA should adopt a two-tier structure for the NEP Obstetric Package Charge by applying its revised rate of $39,000/$48,000 to NEPs with no marital ties in Hong Kong while allowing NEPs whose spouses were Hong Kong residents to pay the old rate of $20,000. They pointed out that many NEP pregnant women

whose spouses were Hong Kong residents were forced to give birth in the Mainland due to lack of financial means, which was detrimental to family unity and social integration. Under the existing immigration policy, babies fathered by Hong Kong residents but born in the Mainland had to apply under the One-way Permit (OWP) Scheme to settle in Hong Kong, whereas Chinese citizens born in Hong Kong had right of abode in Hong Kong regardless of the status of their parents according to Article 24(2)(1) of the Basic Law.

26. The Administration advised that it had no intention to introduce an extra tier in the NEP Obstetric Package Charge for NEP whose spouses were residents of Hong Kong. Under the population policy, eligibility for subsidised public benefits was restricted to holders of Hong Kong Identity Card or children under the age of 11 who were Hong Kong residents. Persons not holding a Hong Kong Identity Card, i.e. NEPs, including Two-way Permit (TWP) holders who were spouses of Hong Kong residents, might access public medical services in Hong Kong by paying the specified charges applicable to them. Whilst recognising that marriages between residents of Hong Kong and the Mainland would become increasingly prevalent, the onus should be on those couples who engaged in cross-boundary marriages to make appropriate plans to meet their medical needs.

27. Members considered the Administration's explanation unacceptable for the following reasons. First, the rate of $20,000 was set on a cost recovery basis. Second, NEPs whose spouses were Hong Kong residents were in effect members of Hong Kong families. Although these NEPs had yet to become residents of Hong Kong under the OWP Scheme, many held TWPs and stayed in Hong Kong throughout the year except for days when they had to return to the Mainland to renew their visit endorsement.

28. The Panel passed a motion urging the Administration to allow NEPs whose spouses were Hong Kong residents to pay the old rate of $20,000. The Administration was requested to provide a written response to the motion by early June 2007, which to date was still outstanding. The Panel is also lining up a joint meeting with the Panel on Welfare Services to discuss with the Administration the eligibility for subsidised public benefits of NEPs whose spouses are Hong Kong residents and those who are not.

Mortuaries in public hospitals

29. In the wake of the mix-up in the collection of deceased patients at the Prince of Wales Hospital (PWH), the Panel held a special meeting to discuss the operation of mortuaries in public hospitals.

30. Members were advised that HA had been requested to conduct a

thorough investigation and ascertain whether there were deficiencies in the relevant systems and procedures and whether human errors were involved and, if so, the improvements measures that would be taken to prevent recurrence of similar incidents in future. HA had undertaken to submit a detailed report to the Health, Welfare and Food Bureau in a month's time. Members were also advised that HA planned to increase the capacity of its mortuaries to 156 additional spaces by the end of 2007, which represented a 10% increase in the mortuary capacity.

31. At the request of Hon Fred LI and Hon WONG Kwok-hing, HA gave an assurance that it would immediately cease storing two deceased bodies of different gender in the same mortuary compartment. HA, however, could not rule out storing two deceased bodies of the same gender in the same mortuary compartment for the time being, due to lack of space. Attempts had been made in the past to seek the consent of the families to move the deceased bodies to another hospital mortuary which had vacant spaces. However, the families concerned were reluctant to do so.

32. The Administration reported to the Panel in June 2007 that the principal cause of the unfortunate mix-up of the bodies of two deceased patients at PWH was human errors. Members were also briefed on the measures to enhance mortuary services in HA, which included adding 220 compartments in 2007-2008 with a further 330 compartments planned for 2008-2009 which should be sufficient to cope with demand for the next 10 years, and expediting the development of the Mortuary Information System to minimise the risk of erroneous body identification.

33. As the average length of storage of the deceased bodies had been increasing in the past few years and was about 15 to 20 days in 2006, Dr Hon KWOK Ka-ki suggested that HA should impose charges on the storage of deceased bodies in its mortuaries. HA agreed to consider charging storage fee where warranted. At the request of Dr Hon Fernando CHEUNG, HA also agreed to review the implementation of the five-day week in HA in respect of the collection of deceased bodies by family members.

Other matters discussed

34. Other subject matters discussed by the Panel included poison prevention and control, telephone booking system for public outpatient services, mode of supply of self-financed items in public hospitals, centralised organ donation register, prevention and control of HIV/AIDS, rationalisation of public hospital services, private services at public hospitals and fee-sharing arrangements, and implications of the 2006 Starting Salaries Survey findings on the subvented organisations in the healthcare sector.

35. The Panel was consulted on the Administration's proposals on the redevelopment of Yan Chai Hospital and Caritas Medical Center, licensing and complaint procedures under the Human Reproductive Technology Ordinance (Cap.561), appeal mechanism for exemptions of organ products under the Human Organ Transplant Ordinance (Cap. 465), amendments to the Quarantine and Prevention of Disease Ordinance (Cap. 141), fixed penalty system for smoking offence, and increase in the commitment for the Health and Health Services Research Fund.

36. From October 2006 to June 2007, the Panel held a total of 16 meetings, including a joint meeting with the Panel on Food Safety and Environmental Hygiene and a joint meeting with the Panel on Welfare Services.

Council Business Division 2
Legislative Council Secretariat
28 June 2007

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 2006 - 2007 session

Chairman	Dr Hon Joseph LEE Kok-long, JP
Deputy Chairman	Dr Hon KWOK Ka-ki
Members	Hon Fred LI Wah-ming, JP
	Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP
	Hon CHAN Yuen-han, JP
	Hon Bernard CHAN, GBS, JP
	Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, 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
	Hon LI Kwok-ying, MH, JP
	Dr Hon Fernando CHEUNG Chiu-hung
	(Total : 14 Members)
Clerk	Miss Mary SO
Legal adviser	Mr Stephen LAM
Date	12 October 2006