立法會
Legislative Council

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LC Paper No. CB(2)773/07-08
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 10 December 2007, at 8:30 am
in Conference Room A of the Legislative Council Building

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

Item IV only

Dr W L CHEUNG
Director (Cluster Services)
Hospital Authority

Dr K M CHOY
Chief Manager (Service Transformation)
Hospital Authority

Item V only

Dr P Y LEUNG
Director (Quality & Safety)
Hospital Authority

Item VI 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. Confirmation of minutes
(LC Paper No. CB(2) 504/07-08)

The minutes of the meeting held on 12 November 2007 were confirmed.

II. Information paper(s) issued since the last meeting

2. There was no information paper issued since the last meeting.

Action

III. Discussion items for the next meeting
(LC Paper Nos. CB(2) 505/07-08(01) and (02))

3. Members agreed to discuss the following items at the next regular meeting to be held on 14 January 2008 -

(a) Allocation of resources among hospital clusters by the Hospital Authority; and

(b) promotion of healthy eating in restaurants.

The Deputy Chairman said that as agreed at the last meeting, deputations would be invited to give views on item (a).

4. Dr KWOK Ka-ki asked when the Administration would release the consultation paper on health care reform and supplementary financing arrangements. Deputy Secretary for Food and Health (Health) (DSFH(Health)) advised that the Administration planned to do in early 2008. It was the Administration's intention to brief members of the Panel in the first instance upon the issue of the consultation paper.

IV. Cataract surgeries programme
(LC Paper No. CB(2)505/07-08(03))

5. Director (Cluster Services), Hospital Authority (Director (CS), HA) briefed members, with the aid of a powerpoint, on a programme to provide subsidies for cataract surgeries for patients in HA so as to shorten waiting time, details of which were set out in the Administration's paper.

Funding of the cataract surgeries programme

6. Mrs Selina CHOW said that in view of the growing demand for cataract surgery brought about by the ageing population, the Administration should provide recurrent funding to HA to make the cataract surgeries programme a permanent one, instead of giving a one-off allocation of $40 million to HA to implement the programme.

7. Dr KWOK Ka-ki indicated support for the cataract surgeries programme. Dr KWOK however hoped that more allocation could be given to HA to implement the programme.

8. DSFH(Health) responded that since co-payment by patients who were not Comprehensive Social Security Assistance (CSSA) recipient was a new

Action

arrangement and a novel platform would be set up under the Public Private Interface/electronic Patient Record (PPI-ePR) Sharing Pilot System for recording patients' information, the Administration considered it necessary to implement the programme on a pilot basis with a view to evaluating the effectiveness of the programme.

Effectiveness of the cataract surgeries programme

9. Mr Vincent FANG noted from paragraph 2 of the Administration's paper that as at 30 June 2007, a total of 48 241 patients were on HA's waiting list for cataract surgery. Mr FANG further noted from paragraph 3 of the same that the annual clinical throughput of cataract surgery in HA was around 16 000 cases while there were around 21 000 projected new cases per year, resulting in a net increase of about 5 000 cases on the waiting list each year. As only 7 000 to 8 000 HA patients would be invited to join the cataract surgeries programme, Mr FANG expressed concern that it would take years for HA to shorten the waiting time for cataract surgery to a reasonable time period.

10. DSFH(Health) responded that patients on the waiting list who were triaged as emergency cases would be given priority treatment by HA hospitals. DSFH(Health) further said that the programme was a move in the direction advocated in the discussion paper entitled "Building a Healthy Tomorrow" issued by the Health and Medical Development Advisory Committee in July 2005 that Hong Kong's public health care service sector should target its services at acute and emergency care; for low income and under-privileged groups; illnesses that entailed high cost, advanced technology and multi-disciplinary professional team work; and training of health care professionals, whereas the private sector should be one that provided choice for the community, among other things.

11. Dr YEUNG Sum said that to better gauge the effectiveness of the programme, a ceiling on the waiting time for patients to receive cataract surgeries should be set.

Capacity of HA in meeting demand for cataract surgery

12. Mr Vincent FANG asked whether HA had the capacity to meet increasing demand for cataract service.

13. Director (CS), HA responded that given the capacity constraint, it was necessary for HA to collaborate with the private sector to increase cataract service. Director (CS), HA further said that there were currently about 100 medical practitioners who were included in the Specialist Register in the specialty of ophthalmology, in accordance with section 20K of the Medical Registration Ordinance. All private ophthalmology specialists practising in any eye centres

Action

and private hospitals who met the above qualification requirement could join the cataract surgeries programme through an enrolment exercise. A list of participated private healthcare providers as well as their related centres/hospitals would be compiled and distributed to the invited patients for reference and selection.

14. Dr YEUNG Sum said that the only effective way to address the present uneven distribution of workload between the public and private sectors was through health care reform and financing. Dr YEUNG urged the Administration to expeditiously publish the consultation paper on health care reform and supplementary financing arrangements.

Selection of patients to join the cataract surgeries programme

15. Mrs Selina CHOW said that elderly patients should be accorded priority for participating in the cataract surgeries programme. Director (CS), HA responded that there was no need for such as almost all of the patients on HA's waiting list for cataract surgeries were elders. Director (CS), HA further said that to achieve the objective of reducing waiting time of patients for cataract surgery, priority would be given to those patients who had been waiting for the longest period on the waiting list. There were currently about 11 000 patients who had been on the waiting list for two or more years. Those who had been waiting the longest period would initially be invited in batches to participate in the programme on a voluntary basis. To be eligible for participation in the programme, a patient should require only local anaesthesia for cataract surgery.

Provision of subsidy for eligible patients

16. Mrs Selina CHOW noted that CSSA patients invited to join the cataract surgeries programme would not have to pay for undertaking cataract surgeries in the private sector. Mrs CHOW urged that similar arrangements be applied to invited patients who were not CSSA recipient if they had difficulty in co-paying their surgeries provided by private ophthalmologists. Dr Fernando CHEUNG expressed similar view.

17. Director (CS), HA responded that invited patients who met the eligibility and assessment criteria for a full fee waiver under HA's fee waiver mechanism would not have to co-pay for their cataract surgeries provided by private ophthalmologists.

18. Dr Fernando CHEUNG said that to ensure that CSSA patients could benefit from the cataract surgeries programme, certain quota should be set aside for this group of patients.

Action

19. Director (CS), HA pointed out that the target patients of the cataract surgeries programme were those who had been waiting longest on HA's waiting list and required only local anaesthesia for the surgery. It was estimated that about 20% of invited patients were CSSA recipients. Director (CS), HA further said that as invited CSSA patients would not have to pay for their surgeries regardless of whether the surgeries were done in HA hospitals/clinics or in the private sector, it was believed that all of them would join the programme. This however might not be the case for invited patients who were not on CSSA, as some of them might choose to stay in normal HA's waiting list.

20. Dr Fernando CHEUNG noted that invited CSSA patients might also participate in the cataract surgeries programme with no need of co-payment, as private providers might offer to conduct the surgery at the subsidised rate without the need for any co-payment. Dr CHEUNG asked about the estimated number of such cases.

21. Director (CS), HA responded that he did not have the information requested by Dr CHEUNG in paragraph 20 above at this stage, until after the participated private healthcare providers had indicated how many cataract surgeries at the subsidised rate they were willing to conduct.

22. Dr KWOK Ka-ki asked whether consideration could be given to setting aside a special fund targeting at reducing the waiting time of CSSA patients for cataract surgery not invited to join the cataract surgeries programme.

23. Director (CS), HA responded that donations from organisations/individuals had and would continue be used to perform cataract surgeries to patients who were on CSSA. For instance, through the assistance from the Lions Eye Bank of Hong Kong, some 2 500 additional cataract surgeries had been performed on patients who were CSSA recipients in the past 18 months.

24. Miss CHAN Yuen-han said that needy patients not on CSSA could ill afford to co-pay for their cataract surgeries provided by the private sector. In the light of this, HA should re-visit the provision of subsidy under the cataract surgeries programme, having regard to the number of such patients involved.

25. DSFH(Health) explained that the provision of subsidy under the cataract surgeries programme was to encourage patients who are able to afford the co-payment to choose to use cataract service in the private sector. Patients who chose not to join the programme could stay in HA's waiting list to receive the heavily-subsidised cataract service provided by HA hospitals/clinics. But in general all patients could benefit from the programme as the overall waiting time for surgeries would be shortened.

Action

26. Dr KWOK Ka-ki said that in order to enable eligible non-CSSA patients with limited economic means to undergo cataract surgery in the private sector, the amount of subsidy should increase from $5,000 to, say, $8,000. Dr KWOK then asked about the basis for determining the amount of subsidy at $5,000 for the cataract surgeries programme.

27. Director (CS), HA responded that the $5,000 subsidy was based on the marginal cost for HA to perform one cataract surgery outside its normal annual cataract throughout of around 16 000 cases. The $5,000 fee would cover partial staff costs and consumables, but excluding premises fee and other operating expenses.

Service monitoring

28. Dr Joseph LEE asked whether it was HA's plan to publicise the names of those participating private ophthalmologists whose surgeries conducted resulted in adverse clinical outcome.

29. Director (CS), HA responded that HA would closely monitor the clinical outcomes of surgeries conducted by participating private ophthalmologists via the PPI-ePR (Cataract Profile) system platform. HA would de-register those private ophthalmologists whose surgeries had unusual complications, after reviewed by an Expert Committee.

Conclusion

30. In closing, Dr Joseph LEE said that members were supportive of the cataract surgeries programme. Some members were however of the view that the amount of subsidy for patients to undergo surgery in the private sector should be increased to enable non-CSSA patients with meagre means to use such service.

V. Hospital Authority Sentinel Event Policy
(LC Paper No. CB(2)505/07-08(04))

31. Director (Quality & Safety), HA briefed members on the sentinel event policy of HA, details of which were given in the Administration’s paper.

32. Chief Executive, HA (CE, HA) sought members' understanding that there would be the impression of increased adverse medical incidents in HA in the short term, as a result of implementing the sentinel event policy in October 2007 to make these incidents public. As a measure to further improve service quality and safety, it was HA's plan to adopt an evidence-based approach in measuring patient outcome by carrying out clinical audits, such as measuring surgical outcome,

Action

across HA next year.

33. Whilst welcoming the sentinel event reporting system, Dr KWOK Ka-ki expressed concern that frontline staff often bore the blame for medical errors, which was unfair as they had to shoulder heavy workload and work long hours. Dr KWOK asked HA how many of the serious medical errors occurred in the past six months were due to human errors and system errors respectively.

34. CE, HA responded that reports of the root cause analysis of medical incidents so far revealed that these incidents were caused by a mix of human and system factors. Although heavy workload had not been found to be a contributing factor to the sentinel events, it could not be ruled out as a possible cause for medical incidents in future. HA was concerned about the heavy workload of its frontline healthcare staff, and had been tackling the issue by reducing the long working hours of doctors, and the high nurse-to-patient ratio also needed addressing. CE, HA further said that HA took a "Just Culture" approach in considering disciplinary action which emphasised a learning approach rather than blaming staff. If investigation reviewed that staff involved in a sentinel event were negligent, the case would be dealt with in accordance with the prevailing HA human resources policy and established disciplinary mechanism. Senior management would be held responsible if they were found to be negligent or if the incident was caused by system failure, such as a lack of clear protocols or guidelines.

35. DSFH(Health) hoped that the public would not view the implementation of the sentinel event policy by HA as laying the blame on the staff involved, as the policy was intended to encourage staff to report sentinel events so that lessons could be learnt from the events to prevent similar medical incidents from happening in the future.

36. Dr Fernando CHEUNG welcomed the implementation of sentinel event policy by HA to further strengthen the reporting, management and monitoring of adverse medical incidents classified as sentinel events in public hospitals. Dr CHEUNG however expressed concern about under-reporting of sentinel events by HA staff, having regard to the vague description of one of the nine specified types of sentinel events required to be reported through a mechanism under HA within 24 hours upon awareness of their occurrence, i.e. "Unexpected death or serious disability reasonably believed to be preventable (not related to the natural course of the individual's illness or underlying conditions), as set out in paragraph 6(i) of the Administration's paper.

37. Director (Quality & Safety), HA responded that under-reporting of medical incidents by HA staff would not arise because firstly, regardless of whether the incidents fell within the nine specified types of sentinel events set out in paragraph

Action

6 of the Administration's paper, the hospital concerned was required to report medical incidents via the HA-wide electronic Advance Incident Reporting System (AIRS) which had been put in place since March 2006. Secondly, actions to be taken by the hospital cluster concerned and by HA Head Office for a sentinel event, as mentioned in paragraphs 7 and 8 of the Administration's paper respectively, would also be required for major incidents which did not fall within any of the aforesaid nine categories if warranted.

38. Miss CHAN Yuen-han indicated support for HA's sentinel event policy for improving patient safety. Miss CHAN enquired whether staff had been consulted on the new reporting system, as the implementation of which would add to the already heavy workload of frontline healthcare staff.

39. CE, HA responded that the implementation of the sentinel event reporting system would not increase the workload of frontline staff, as they were presently required to report all medical incidents via AIRS. On the contrary, staff would know how to better manage a serious medical incident in which they were involved and prevent extra pressure arising from medical incidents in the future.

40. Director (Quality & Safety), HA said that HA had consulted staff of all hospital clusters before implementing the new reporting system, and responses from staff were generally positive. Director (Quality & Safety), HA further said that each hospital cluster had a critical incident support team that stood ready to render support to staff involved in medical incidents.

41. Dr YEUNG Sum said that the sentinel event policy of HA should be underpinned by the following principles: (i) ensuring the independence of the investigation panel; (ii) disclosing the event to the public within a specified time frame but only after the patient and his/her family had been informed of the incident; (iii) prompt implementation of improvement measures; and (iv) appropriate compensation to patients concerned.

42. CE, HA responded that not all sentinel events would call for the appointment of an investigation panel, for instance, cases involving death of an in-patient from suicide did not normally warrant the setting up of such a panel. CE, HA further said that upon the occurrence of a sentinel event, the patient concerned and his/her family would invariably be notified before the event was made known to the public. To enhance accountability to the public, HA would compile, every six months, a report on sentinel events for release to the public, and the first report covering the period from October 2007 to April 2008 was expected to be released to the public in June 2008. Furthermore, a "Risk Alert" bulletin would be issued on a bi-monthly basis to all HA staff on the learning points from the reported sentinel events. As regards compensation to patients, CE, HA pointed out that it would be a matter for the court to decide.

Action

43. In closing, Dr Joseph LEE hoped that the sentinel event reporting system could be made more open and transparent to instil greater public confidence in HA services.

VI. Review of Hospital Authority's Private Patient Revenue Management System

(LC Paper No. CB(2)505/07-08(05) and (06))

44. Director (Finance), HA briefed members on the findings of an internal review conducted by HA on its private patient revenue management system, details of which were set out in the Administration's paper (LC Paper No. CB(2)505/07-08(05)).

45. Dr KWOK Ka-ki said that the two universities with medical faculties, i.e. the University of Hong Kong (HKU) and the Chinese University of Hong Kong (CUHK), apportioned income generated from private patient services to staff providing such services. For instance, the Li Ka Shing Faculty of Medicine of HKU had apportioned as high as 50% of the income from private patient services to the staff concerned since April last year. In the light of this, Dr KWOK asked the following questions -

(a) when would HKU draw up the guidelines and criteria for the granting of fee waiver to private patients;

(b) how frequent would HA conduct sample checking of medical records against the billing records of private patients to ensure that all private services were properly recorded and billed according to the prevailing fees and charges;

(c) whether the development of a new patient billing system for further integration of the different billing and clinical systems of HA could be expedited; and

(d) whether HA could fully recover the costs for its private services under the existing fee sharing arrangements between HA and the two universities with medical faculties.

46. Director (Finance), HA responded as follows -

(a) it was HA's understanding that HKU was reviewing the criteria for granting fee waiver to private patients. Queen Mary Hospital (QMH) was following up with HKU on the documentation of a more formal fee waiver system which included open and transparent guidelines.

Action

This was to ensure that pre-approval for fee waiver to private patients was obtained from HKU prior to medical services being rendered, and would help reduce the potential risk of inappropriate fee waivers being granted by individual HKU staff;

(b) as checking of medical records to billing records was time-consuming, only several medical records of private patients in QMH and PWH would be selected each month for checking to avoid increasing the already heavy workload of frontline healthcare staff. The number of samples for checking might appear small, it nevertheless represented more than 10% of the private patient cases handled by each of the two teaching hospitals;

(c) there would be practical difficulty in advancing the completion time of the development of the new patient billing system, as such development involved full integration and automation of the charging process requiring complex multi-system interfaces from and modification of various clinical systems and standardisation of the definition of services; and

(d) HA charged market rates for its private patient services, which were set at least at the cost recovery levels, to ensure that the normal operation of the private markets would not be interfered. Under the fee sharing arrangements for private patient services agreed between HA and the two universities with medical faculties, there was no refund to the universities after collection of maintenance and medication fees by HA because all the costs were borne by HA. For income earned from doctor fee (for in-patient), consultation fee (for out-patient), and itemised charges (for both in and out-patients, including diagnostic and therapeutic/operative procedures), it was shared between the relevant clusters of HA and the universities ranging from 25% and 75% respectively. For instance, the universities would receive 75% of the fee collected for surgery, while HA would retain the remaining 25%.

47. DSFH(Health) supplemented as follows -

(a) HA's private patient services was provided on a limited scale, i.e. less than 1% of the overall services provided at HA, to offer patients with the means for accessing specialised services not generally available in the private sector;

(b) to ensure that public medical services would not be adversely affected by the provision of private patient services, there were

Action

guidelines in place at public hospitals which restricted the time each doctor could devote to such 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; and

(c) neither HA nor the Government possessed information or had a say on how the two universities apportioned their income generated from private patient services, as the universities had full autonomy in the management of their internal affairs and finance. In the provision of private patient services, the primary concern of HA was to ensure that such services would not adversely affect public patient services and that income generated from such services were properly recorded, charged and audited.

48. Mrs Selina CHOW asked the following questions -

(a) whether, and if so, what action would be taken by HA to expedite the private patient billing process, prior to the implementation of the new patient billing system;

(b) whether HA had encountered any problem in the collection of fees for private patient services; and

(c) when the review on the variations in practice between different hospitals on the billing of private patients would commence.

49. Director (Finance), HA responded as follows -

(a) to ensure timely billing of private patient services until the implementation of the new patient billing system, the two teaching hospitals had agreed to target the issuance of final bills for private patient services within seven days from discharge;

(b) default payment of fees was not a problem for private patient services generally; and

(c) it was envisaged that HA could start discussing with the two universities early next year on removing the variations in practice by QMH and PWH on the billing of private patients.

50. In closing, Dr YEUNG Sum suggested to invite representatives from HKU and CUHK to discuss billing arrangements for private patients at a future meeting. Dr KWOK Ka-ki expressed support. Dr Joseph LEE said that the matter should be referred to the Chairman for consideration.

Action

VII. Any other business

51. There being no other business, the meeting ended at 10:45 am.

Council Business Division 2
Legislative Council Secretariat
11 January 2008