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Legislative Council

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LC Paper No. CB(2)1049/07-08
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 14 January 2008, at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Hon LI Kwok-ying, MH, JP (Chairman) 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 Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung
Members absent	:	Hon Mrs Sophie LEUNG LAU Yau-fun, GBS, JP Hon LEUNG Kwok-hung
Public Officers attending	:	Items III, IV & V Mr Patrick NIP, JP Deputy Secretary for Food and Health (Health) Items III & IV Miss Gloria LO Principal Assistant Secretary for Food & Health (Health)

Mr Shane SOLOMON
Chief Executive
Hospital Authority

Dr W L CHEUNG
Director (Cluster Services)
Hospital Authority

Item V only

Miss Pamela LAM
Principal Assistant Secretary for Food & Health (Health)

Dr LEUNG Ting-hung, JP
Head, Surveillance & Epidemiology Branch
Department of Health

Dr Regina CHING
Assistant Director of Health (Health Promotion)
Department of Health

Attendance by invitation :

Item IV only

Alice Ho Miu Ling Nethersole Hospital Doctors' Association

Dr Richard YEUNG Sai-dat
Consultant

Dr KWONG Shu-keung
Senior Medical Officer

Hong Kong Public Hospitals, Department of Health and University Doctors' Association

Dr P C PAN
Vice-Chairman

Dr K H YEUNG
Council Member

Hong Kong Public Doctors' Association

Dr HO Hung-kwong
President

Dr HO Pak-leung
Vice-President

Alliance for Patients' Mutual Help Organizations

Mr CHEUNG Tak-hai
Chairperson

Mr YIP Wing-tong
Vice-Chairperson

Dr LAU Yuk-kong
Consultant Cardiologist

United Christian Hospital Doctors' Association

Dr M F LEUNG

Dr CHENG Chung-kit

Hong Kong Association of the Pharmaceutical Industry

Mr Steven Hardacre
President

Ms Sabrina CHAN
Executive Director

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

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I. Confirmation of minutes
(LC Paper No. CB(2) 773/07-08)

The minutes of the meeting held on 10 December 2007 were confirmed.

II. Information papers issued since the last meeting

2. Members noted the following papers issued since the last meeting and did not raise any queries -

(a) a submission dated 26 December 2007 from a member of the public concerning the Hospital Authority (HA)'s refund policy for the obstetric package charges paid by non-eligible persons (LC Paper No. CB(2)726/07-08(01));

(b) a joint submission from 關注香港中醫藥政策聯會, 中華古醫藥保存協會and香港中醫執業資格試權益組 requesting that a council be set up under the Government to promote the development of Chinese medicine in Hong Kong and the Administration's response (LC Paper Nos. CB(2)749/07-08(01) and (02));

(c) an information paper prepared by the Complaints Division of the Legislative Council Secretariat on health care services for the elderly (LC Paper No. CB(2)750/07-08(01)); and

(d) a submission dated 5 January 2008 from Clean the Air urging the Government to protect all people from passive smoking at work (LC Paper No. CB(2)793/07-08(01)).

III. Discussion items for the next meeting
(LC Paper Nos. CB(2) 774/07-08(01) and (02))

3. As the second Monday in February 2008, i.e. 11 February, immediately followed the Lunar New Year public holidays, members agreed to defer the next regular meeting to 18 February at 8:30 am to discuss the following issues -

(a) Review of the obstetric package charge for non-eligible persons; and

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(b) Monitoring of unregistered drug used or contained in slimming products.

4. Dr KWOK Ka-ki suggested and members agreed to discuss HA's Doctor Work Reform Recommendation Report in March 2008.

IV. Allocation of resources among hospital clusters by the Hospital Authority
(LC Paper Nos. CB(2)774/07-08(03), (05) to (07), CB(2)865/07-08(01) to (03))

5. Chief Executive, HA (CE, HA) highlighted the principles and mechanism of resource allocation among hospital clusters by HA, details of which were set out in the Administration's paper (LC Paper No. CB(2)774/07-08(03)).

Views of deputations

Healthcare sector

6. The following deputations/individual from the healthcare sector presented their views as detailed in their submissions -

(a) Alice Ho Miu Ling Nethersole Hospital Doctors' Association (LC Paper No. CB(2)774/07-8(05));

(b) Hong Kong Public Hospitals, Department of Health and University Doctors' Association (LC Paper No. CB(2)774/07-8(06));

(c) Hong Kong Public Consultant Doctors Group (LC Paper No. CB(2)774/07-8(07));

(d) Hong Kong Public Doctors' Association (LC Paper No. CB(2)865/07-8(01));

(e) Dr LAU Yuk-kong, Ruttonjee Hospital (LC Paper No. CB(2)865/07-8(02)); and

(f) United Christian Hospital Doctors' Association.

Major views expressed were as follows -

(a) allocation of resources among hospitals within each cluster was skewed to the acute regional hospital. A case in point was the

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cessation of a number of specialist services in other acute hospitals in the New Territories East (NTE) Cluster and the New Territories West (NTW) Cluster in recent years;

(b) allocation of resources among clusters was also skewed to clusters in the developed urban areas. Although the Kowloon East (KE) Cluster served a population of some one million of the Kwun Tong and Tseung Kwan O districts, its annual funding came to only some $2.6 billion as opposed to some $6.3 billion for the Hong Kong East Cluster and the Hong Kong West Cluster serving a combined population of less than 1.5 million;

(c) as resources and specialist services were concentrated in acute regional hospitals, not only were services to patients living in the vicinity of other acute hospitals being undermined, promotion prospect of doctors in these hospitals were at a disadvantage vis-à-vis their counterparts in acute regional hospitals; and

(d) to address the problems outlined in (a)-(c), HA should -

(i) clearly delineate the role of hospitals within each cluster to avoid workload spilling over from acute regional hospital to other acute hospitals which were not adequately funded to cope with the additional workload;

(ii) establish standards for allocation of resources, such as bed-to-population ratio and ratio of healthcare professionals to patients with similar illness, so as to ensure that hospitals delivering services would receive similar funding;

(iii) provide all other acute hospitals with essential diagnostic equipment such as magnetic resonance imaging scanner, and facilities such as intensive care wards, so that all patients could receive the same level of primary and secondary care regardless of whether they patronised an acute regional hospital or otherwise. Selected specialist services should be provided in other acute hospitals as far as practicable, if the provision of such would not entail high cost;

(iv) rotate Hospital Chief Executives (HCEs) to take turn to concurrently serve as Cluster Chief Executive (CCE) for a specified time period or recruit someone to serve separately as CCE, so as to prevent a CCE from favouring the hospital to which he/she served as HCE in the allocation of resources. Similar arrangement should be made for doctors serving as

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head of a specialist service at the hospital level;

(v) include feedback from frontline doctors in the appointment/renewal of contract of CCEs and HCEs; and

(vi) improve its communication with frontline staff, which at present was top-down.

Patients' group

7. Mr CHEUNG Tak-hai from the Alliance for Patients' Mutual Help Organization said that following the implementation of HA Drug Formulary in 2005, some patients complained that they were no longer supplied with certain drugs after being transferred from a specialist out-patient clinic (SOPC) to a general out-patient clinic for treatment or had to pay for certain drugs at market rate at a secondary hospital which were supplied at the standard charge of $10 per drug item at an acute regional hospital which they previously patronised. Mr CHEUNG was of the view that such variation in practice was due to the fact that HA could only spend about 6% of its yearly budget on purchasing drugs because of insufficient funding, and urged that more funding be allocated to HA to ensure consistent access to drugs by patients.

Pharmaceutical industry

8. Mr Steven Hardacre presented the views of Hong Kong Association of the Pharmaceutical Industry as set out in its submission (LC Paper No. CB(2)865/07-8(03)). Specifically, the Association said that the Administration should provide more funding to HA to enable it to purchase more new drugs and require all public hospitals to stock all drugs included in the Formulary to provide quality care to all patients.

Responses from HA

9. CE, HA said that -

(a) it was HA's objective to see that all hospital clusters were provided with adequate baseline resources for maintaining the delivery of required level of primary and secondary services. In so doing, consideration would also be given to the size of population, demographic profile and service utilisation pattern of each cluster to allow it to maintain, develop and expand its current service as appropriate. To that end, additional resources would be provided to clusters which were currently underprovided. For instance, more beds would be added to Pok Oi Hospital and Tuen Mun Rehabilitation Block in the NTW Cluster in 2007-2008, expansion

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plans for Tseung Kwan O Hospital (TKOH) and Haven of Hope Hospital (HHH) in the KE Cluster were being drawn up, a hospital was planned for North Lantau, and the construction of a hospital in Tin Shui Wai was being explored by the Administration;

(b) it would, however, not be an efficient use of resources for every hospital in a cluster to be 100% self-sufficient in the provision of primary and secondary care, as some patients might prefer to seek treatment from other hospitals in the cluster, for example, closer to their place of work. Moreover, it was necessary for certain specialised services to be centralised in one or two hospitals within a cluster to secure the necessary critical mass of workload to sustain quality outcomes and to ensure value for money for patients. For highly specialised services, there might be only one or two centres across Hong Kong;

(c) as tertiary and highly specialised services, such as organ transplant and open heart surgery, had relatively small number of caseloads and required some state-of-the-art technologies, equipment and comprehensive supporting facilities for delivery, it was necessary to target provision of such services at designated hospitals to achieve cost-effectiveness and to ensure the quality of services by pooling together the experience and expertise of healthcare professionals;

(d) HA had no plan to rotate HCEs who concurrently serve as CCE, as two of the seven CCEs were approaching retirement and most of the remaining five CCEs had been in post for less than three years. Recruiting additional staff to serve as HCEs of major cluster hospitals would entail very high cost. However, consideration was currently being given to rotating HCEs to work at other hospitals to revitalise management;

(e) to ensure that the apparent conflict of interest for a HCE of an acute regional hospital to concurrently serve as CCE would not translate into unfairness in the allocation of resources, the best solution was to put in place a mechanism to see how resources were allocated from the cluster level to the hospital level. To that end, a new internal funding allocation model was being developed by HA to challenge and question the existing funding arrangements to clusters in areas such as whether the workload of staff and provision of equipment were similar in hospitals providing the same services. The new model would also help to shed light on developing workforce and equipment indicators to improve transparency and fairness in the allocation of resources among/within clusters. If it was revealed that secondary hospitals had been historically

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disadvantaged, action would be taken to increase resources to these hospitals progressively;

(f) hospital clustering provided a framework for hospital role delineation and a basis for planning the organisation and provision of healthcare services. Hence, the important thing was to make clustering work rather than to dismantle it. As the clustering arrangement of public hospitals had been operating since 2000, a Cluster Review Panel had been set up by HA to see what and how improvements should be made to the clustering arrangement. The Cluster Review Panel would re-convene next month. Deputations would be invited to present their views to the Cluster Review Panel;

(g) the suggestion of incorporating staff feedback in the appointment/renewal of contract of CCEs, HCEs and senior doctors was worth pursuing, and reference would be drawn from similar practice adopted by local universities; and

(h) HA had set up a committee to work out new promotion system for senior specialists. The committee's report would be available shortly.

10. Director (Cluster Services), HA said that -

(a) a key objective of the implementation of HA Drug Formulary was to standardise drug charging policy and utilisation across all HA hospitals and clinics to ensure that patients in similar clinical conditions would have similar access to drug therapy. The fact that a patient patronised another public hospital or clinic should not affect his/her drug therapy, including his/her charge for the drugs, so long as his/her clinical conditions remained unchanged. On the other hand, if the clinical conditions of a patient changed, drugs prescribed to that patient would accordingly be changed;

(b) introduction of new drugs into the Formulary was regularly conducted by HA Drug Advisory Committee based on criteria such as scientific evidence of efficacy and safety as well as cost-effectiveness; and

(c) it was not practical to require all public hospitals to stock all drugs included in the Formulary, which currently numbered over 1 000 items, as the targeted patients of, say, an acute hospital, were different from those of a rehabilitation hospital.

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Discussion

11. Dr KWOK Ka-ki urged the Administration to provide sufficient funding to HA to enable it to address the uneven allocation of resources among/within clusters, as evidenced by the serious deprivation of resources in the KE Cluster, the NTE Cluster and the NTW Cluster.

12. Deputy Secretary for Food and Health (Health) (DSFH(Health)) responded that to help HA cope with resource requirements arising from the increase in service demand, the Administration had undertaken to provide HA with additional recurrent funding of around $300 million each year from 2006-2007 to 2008-2009. Apart from this, additional allocations had been given to HA for the implementation of new initiatives and services programmes, including those related to specific clusters. For instance, the Administration had in the past given additional allocation to provide support to the KE Cluster and the NTW Cluster. The subvention received from the Administration was allocated within HA in accordance with the established mechanism, having regard to the priority of various initiatives and the circumstances and requirements in individual clusters. HA would continue to seek necessary improvements to its internal funding arrangements in the light of experience.

13. CE, HA said that under-provision of healthcare services in specific clusters had to be solved step-by-step, as crucial elements, such as physical capacity and staffing resources, could not be made available overnight. Nevertheless, the general principle held by HA in the allocation of resources among/within clusters was that resources should be similar in hospitals if they were treating similar patients. In other words, money provided to hospitals for performing, say, a cataract operation, should be the same across all hospitals for providing such operation. The new internal funding allocation model mentioned in paragraph 9(e) above was aimed to ensure such.

14. Miss CHAN Yuen-han said that HA should take into account the size of and income level of population, demographic profile and service demand of each cluster in allocating resources among hospital clusters. Miss CHAN then asked whether HA had any plan in hand to ensure the provision of adequate healthcare services in rapidly developing areas such as Tin Shui Wai. Sharing the concern expressed by deputations from the healthcare sector about the tendency of CCEs favouring the hospitals to which they also served as HCEs in the allocation of resources, Miss CHAN enquired about the selection criteria of CCE.

15. CE, HA responded as follows -

(a) apart from allocating resources to clusters on the basis of what services clusters were providing, consideration would also be given to the size of population, demographic profile and service utilisation

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pattern of each cluster for necessary adjustment to its funding allocation to allow specific cluster to maintain, develop and expand its current service as appropriate;

(b) a new Strategy and Planning Division had been created in HA last year to work out what workforce and services were required to meet patients' demand in the long run. HA would be happy to revert to the Panel progress made in this regard in due course. In the interim, additional resources would be allocated to undersupplied areas by building new hospitals or progressively opening new beds; and

(c) he was not in a position to answer how CCE was appointed, as no such appointment had been made since his taking office at HA almost two years ago. In view of the importance of building up a leadership capacity within HA, consideration was being given to rotating HCEs to work at other hospitals to widen their experience and exposure.

16. Mr Vincent FANG declared that he was the Chairman of the Hospital Governing Committee of Princess Margaret Hospital. Mr FANG further said that the root of the grievances lay in insufficient funding to HA. In view of the huge fiscal surplus that was expected for this financial year, Mr FANG urged the Administration to increase funding to HA. Mr FANG concurred with deputations from the healthcare sector that HA needed to strengthen its communication with staff, develop objective indicators for allocation of resources and solicit staff feedback in the appointment/renewal of contract of senior managers and doctors. Mrs Selina CHOW expressed similar views.

17. DSFH(Health) responded that based on the agreed funding arrangements for the three years from 2006-2007, the recurrent funding to HA for 2008-2009 would be increased by no less than $300 million. He remarked that apart from the recurrent subvention to HA, the Administration would also allocate non-recurrent provisions to HA to cover the expenditure on equipment and information systems. For instance, around $500 million had been allocated to HA for replacement of equipment in 2007-2008. The funding allocation to HA in the coming year would be determined in the 2008-2009 Budget.

18. Mr Fred LI said that he failed to see how HA had taken into consideration the size of population, demographic profile and service utilisation pattern of each cluster for necessary adjustment to its funding allocation to allow specific cluster to maintain, develop and expand its current service as appropriate. Mr LI pointed out that if that was the case, the United Christian Hospital (UCH) would not be failing in carrying out its role of an acute regional hospital in the KE Cluster. Cases in point were that the waiting time for new cases in the SOPC at UCH was the longest among HA hospitals, and the rehabilitation services that UCH provided

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were in acute shortage. Mr LI urged HA to expeditiously address these deficiencies as patients living in areas covered by the KE Cluster should not be deprived of the same level of healthcare services enjoyed by patients living in areas covered by the two hospital clusters in the Hong Kong Island region.

19. CE, HA disagreed that better healthcare services depended on where one lived. All patients would be treated properly and given the best possible care in all HA hospitals and clinics, albeit some of them might have to travel a bit further to receive care. CE, HA further said that the solution to meet patients' need lay in identifying what and where services were needed and formulating plans to realise them progressively. Hence, HA would not merely be looking at expanding UCH in meeting patients' need, but would also be looking at the total configuration of services within the KE Cluster and the abridging clusters. In the interim, services in TKOH and HHH would be expanded to relieve the pressure of UCH.

20. Whilst recognising the merits of the clustering arrangement of public hospitals as set out in paragraph 3 of the Administration's paper, Dr YEUNG Sum said that these merits could not be fully realised without changing the existing management structure and culture in HA, such as the permanent appointment of CCEs, which had given rise to inequity in the allocation of resources among/within clusters. Dr YEUNG urged that an independent expert committee comprising all stakeholders be set up to undertake a comprehensive review of the clustering arrangement of HA hospitals and submit periodic reports to the Panel. Dr Fernando CHEUNG expressed similar views.

21. CE, HA responded that the HA Cluster Review Panel already had a strong element of independence to it, as it was chaired by a retired CCE and comprised two overseas experts from Australia. The Cluster Review Panel had conducted one round of consultation so far, and would re-convene some time next month. HA would be happy to organise a meeting for deputations attending the meeting to meet with the Cluster Review Panel. DSFH(Health) supplemented that the Administration would follow-up with HA on the suggestions regarding the appointment of CCE and HCE, as well as the findings and recommendations of the review by HA on the clustering arrangement of public hospitals.

22. Mrs Selina CHOW said that she did not see the need of setting up another independent committee to review the clustering arrangement of HA hospitals. Mrs CHOW however hoped that the HA Cluster Review Panel would involve all stakeholders in its review process.

23. CE, HA assured members that the HA Cluster Review Panel would meet with deputations attending the meeting when it re-convened next month. CE, HA further assured members that the Cluster Review Panel would solicit the views of all stakeholders before finalising its report which would be made public.

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24. Dr Joseph LEE asked -

(a) whether the Administration had any plan to set up an independent committee to review HA which had been established for over 17 years; and

(b) in what ways would the new internal funding allocation model under development address the inequities in the existing allocation of resources among/within clusters.

25. DSFH(Health) replied that the Administration had at present no plan to conduct the review as suggested by Dr LEE. The present focus was on taking forward the health care reform along the directions outlined in the consultation document published in July 2005. In this regard, HA would position itself to seek improvements on its priority areas (i.e. acute and emergency service, services for the low income group and the underprivileged, illnesses that entailed high cost, advanced technology and multi-disciplinary professional team work in their treatment, and training of healthcare professionals). In the meantime, HA would continue to review its internal operation, including the funding allocation arrangements and management of its clusters, as well as the career structure of staff with a view to improving its systems for more effective delivery of public healthcare services.

26. As regards Dr LEE's second question, CE, HA said that work on developing the new internal funding allocation model was well advanced. It was HA's intention to come up with a draft budget model this year for implementation next year. Depending on how large any inequities were within/among clusters, full implementation of the new internal funding model might need to take more than one year. CE, HA further said that the new internal funding allocation model was aimed at addressing the unfairness in the allocation of resources to existing services, and was not about addressing the unfairness in the population-based funding.

27. Mr Andrew CHENG enquired about the criteria for allocation of additional funds to specific clusters for implementation of new initiatives and designated programmes referred to in paragraph 11(b) of the Administration's paper.

28. CE, HA responded that he would meet with the co-ordinating committee of each of the 35 clinical specialty each year to discuss their funding needs for new clinical programmes, which would then be prioritised by the Medical Policy Group by using an evaluation methodology based on the strength of evidence, service impact and degree of achievability.

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Motion

29. Dr KWOK Ka-ki moved the following motion -

"本會促請政府責成醫院管理局改革其聯網制，糾正不同聯網間及聯網內不同醫院資源分配不均的情況，亦應增加撥款以改善九龍東、新界西及新界東聯網等醫院聯網資源嚴重不足的情況。"

(Translation)

"That this Panel urges the Government to demand the Hospital Authority to reform its clustering arrangement so as to address the uneven distribution of resources among clusters and among hospitals within the same cluster, and to allocate more funding to improve the serious shortage of resources in hospital clusters such as the Kowloon East, the New Territories West and the New Territories East Clusters."

Dr YEUNG Sum proposed amendments to Dr KWOK's motion as follows -

"本會促請政府責成醫院管理局改革其聯網制，糾正不同聯網間及聯網內不同醫院資源分配不均的情況，亦應增加撥款以改善九龍東、新界西及新界東聯網等醫院聯網資源嚴重不足的情況，*以及成立一個包括前線員工和病人組織的獨立小組，全面檢討聯網的成效*。"

(Translation)

"That this Panel urges the Government to demand the Hospital Authority to reform its clustering arrangement so as to address the uneven distribution of resources among clusters and among hospitals within the same cluster, and to allocate more funding to improve the serious shortage of resources in hospital clusters such as the Kowloon East, the New Territories West and the New Territories East Clusters***, as well as to set up an independent committee comprising frontline staff and patients' groups to comprehensively review the effectiveness of the clustering arrangement***."

The Chairman put Dr YEUNG's amendments to Dr KWOK's motion to vote. All members present voted in favour of Dr YEUNG's amendments to Dr KWOK's motion. The Chairman declared that Dr KWOK's motion, as amended by Dr YEUNG, was carried.

Conclusion

Admin

30. In closing, the Chairman requested the Administration to revert to members in six months' time on the motion carried, the development of the new internal

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funding allocation model, the suggestion of rotating HCEs to also serve as CCE and the progress made in rotating HCEs to work at other hospitals.

V. Promotion of healthy eating in restaurants
(LC Paper No. CB(2)774/07-08(04))

31. DSFH(Health) briefed members on a campaign to promote healthy eating in restaurants, which would be launched by the Department of Health (DH) in collaboration with restaurants in Hong Kong, details of which were given in the Administration's paper.

32. Dr YEUNG Sum enquired about measures to encourage restaurants to participate in the campaign to promote healthy eating in restaurants (the Campaign).

33. Assistant Director of Health (Health Promotion) (ADH(HP)) responded that DH believed that more restaurants would participate in the Campaign if more people became aware of the importance of choosing healthy dishes when dining out. To that end, DH would launch a territory-wide publicity drive in early 2008 and the public might access a list of participating restaurants from the webpage or recognise them from the decal exhibited prominently in the premises.

34. Mr Fred LI said that to further promote healthy eating in restaurants, participating restaurants should be encouraged to offer dishes with smaller serving and make known to customers the calories of each dish as well as the ingredients used.

35. ADH(HP) responded that Mr LI's suggestions were worth pursuing. However, as the Campaign was new, present focus would be placed on encouraging and assisting restaurants to provide more dishes with fruit and vegetables as main ingredients, and with less oil, salt and sugar, which should be easier to follow.

36. Mrs Selina CHOW welcomed the launch of the Campaign. Mrs CHOW suggested organising a large-scale publicity event to raise public awareness of the Campaign, and arranging people to pose as customers to find out whether participating restaurants had met the requirements of the Campaign and to give recognition to those participating restaurants which had met such requirements.

37. Dr KWOK Ka-ki expressed support for the Campaign. Dr KWOK further asked the following questions -

(a) whether consideration would be given to operating a validation system to ensure participating restaurants met the requirements of the

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Campaign;

(b) whether DH had adequate resources to promote the Campaign; and

(c) how long would the Campaign last.

38. ADH(HP) responded as follows -

(a) to enrol in the Campaign, a restaurant had to provide relevant training to their staff and provide recipes of at least five EatSmart dishes for assessment by DH. Enrolment status of participating restaurants would be valid for one year, and re-enrolment would be subject to assessment by DH. To ensure that the participating restaurants had met the requirements of the Campaign, DH would conduct random visits to the restaurant. If feedback from visits or customers' opinions indicated that a participating restaurant had inadequacies, DH would require the restaurant to follow up and confirm in writing within two weeks that improvement measures had been taken;

(b) publicity work of the Campaign was funded by the Central Health Education Unit of DH; and

(c) the Campaign was intended to be an ongoing initiative.

39. In closing, the Chairman said that members generally supported the Campaign and urged the Administration to take account of members' views and suggestions in promoting healthy eating in restaurants.

VI. Any other business

40. There being no other business, the meeting ended at 10:39 am.

Council Business Division 2
Legislative Council Secretariat
15 February 2008