立法會

Legislative Council

LC Paper No. CB(2)2448/07-08

Ref : CB2/PL/HS

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

Purpose

This report gives an account of the work of the Panel on Health Services (the Panel) during the 2007-2008 Legislative Council session. It will be tabled at the Council meeting on 2 July 2008 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, 9 October 2002 and 11 July 2007 for the purpose of monitoring and examining Government policies and issues of public concern relating to health services matters.

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

4. The Panel comprises 13 members, with Hon LI Kwok-ying and Dr Hon Joseph LEE Kok-long elected as Chairman and Deputy Chairman respectively. The membership list of the Panel is in **Appendix II**.

Major work

Consultation on healthcare reform

5. The Panel held two meetings with the Administration to discuss the Healthcare Reform Consultation Document entitled "Your Health, Your Life"

released on 13 March 2008. The Panel also met with a total of 64 organisations/individuals in two public hearings to listen to their views on the proposals contained in the Consultation Document.

6. Members were generally supportive of the service reform proposals, viz. enhancing primary healthcare service, developing an electronic database of patient records, strengthening public healthcare safety net, and promoting greater public-private healthcare partnership. They urged the Administration not to wait for the implementation of supplementary financing arrangements before embarking on the service reforms. Dr Hon KWOK Ka-ki further urged the Administration to increase its expenditure on healthcare, which currently accounted for only some 14.3% of recurrent government expenditure and was on the low side in comparison with other developed economies, in order to address the shortcomings in the present healthcare system.

7. The Administration advised that it had already embarked on pilot projects to take forward the various service reforms. To sustain the improvements in healthcare services and to enhance the health of the community in the long term, it was necessary to introduce supplementary financing to provide a stable and sustainable funding source. The Administration further advised that the Government's commitment to public healthcare would only be increased and not reduced. The Chief Executive (CE) had pledged to increase government expenditure on healthcare from 15% to 17% of recurrent government expenditure by 2011-2012. The Government would continue to be the main financing source for healthcare services. Setting aside $50 billion from the fiscal reserve to assist the implementation of healthcare reform demonstrated the Government’s commitment to share the responsibility for healthcare financing together with the community and to increase the resources available to individual members of the community for healthcare.

8. Members as well as deputations' views on the six supplementary financing options proposed in the Consultation Document were mixed. They pointed out that the extra benefit of requiring people to contribute, say, 3% to 5%, of their monthly income to a mandatory savings account was not apparent. Although encouraging more individuals to take out private health insurance was worthy of support, there was a lack of regulation over the malpractice of private insurers by the Government. Concern was raised as to whether the benefit coverage of mandatory health insurance would be adequate to cover the medical costs of the insured without raising the level of premium over time. It was also questionable whether the personal healthcare reserve option was viable, as the Government's figures did not take into account increases in the monthly premium over time due to the increasing age profile of the participants in the insurance and rising medical costs as well as the fact that the insured might need to undergo one

to two minor surgeries before their retirement thereby exhausting their accrued savings to subscribe to their medical insurance. In particular, members shared the concern that the middle-class would be the biggest loser if supplementary financing was introduced.

9. The Administration pointed out that the middle-income group would be the biggest loser if nothing was done to sustain the healthcare system to meet the challenges due to an ageing population and rising medical costs brought about by advances in medical technology. Although those with middle-income or above were the ones paying tax to fund the public healthcare system, many of them were already purchasing private health insurance or paying out of their own pockets to use services provided by private healthcare providers because of the long waiting time for many public healthcare services. Hence, the middle-income group in effect received less under the present healthcare system. On the other hand, supplementary financing arrangements could bring the middle-income group more value-for-money healthcare services, more quality choices and more comprehensive healthcare protection. The middle-income group could continue to use highly-subsidised public healthcare services if they so chose, especially if struck by catastrophic illnesses or requiring complicated surgery or treatments, after the proposed healthcare reform.

10. The Administration also advised that if mandatory private medical insurance was to be introduced, a transitional mechanism might be put in place for those who had already taken out health insurance themselves, or for employers who had provided medical insurance for their employees, so that they could migrate their existing insurance schemes to the mandatory private health insurance scheme regulated by the Government. Generally speaking, the terms under the mandatory private health insurance scheme should be more favourable to the insured and the premium should be lower. However, if there were existing insurance schemes, including those taken out by employers to provide medical benefits to their employees that provided better terms than the mandatory one, exemption or other transitional arrangements could be considered.

11. Some members criticised the lack of details in the Consultation Document to facilitate meaningful discussion. The Administration advised that as healthcare reform was a highly complex issue which involved many different aspirations, values and decisions of the society, a two-stage consultation approach was adopted to engage the public in taking forward the reform. During this first stage consultation, no particular option on supplementary financing was recommended. Instead, public views would be sought on the key principles and concepts of the service reform proposals, and the pros and cons of possible supplementary financing options. On the basis of the views received during the first stage consultation, detailed proposals for the reform, including those of

supplementary financing arrangements, would be formulated for a second stage consultation.

12. The Administration reported to the Panel on 16 June 2008 that over 4 300 submissions were received at the conclusion of the first stage consultation ending 13 June 2008. The consultation showed that the public generally supported the healthcare reform proposals. There were also calls for implementing these reforms more quickly and vigorously. To the public, a major concern was the kind of healthcare protection which they could gain by contributing to a financing option. The Administration would take into account concerns expressed by different sectors of the community when devising more concrete proposals for second-stage consultation aimed to take place in the first half of 2009.

Elderly health care voucher pilot scheme

13. The CE announced in his 2007-2008 Policy Address of the Administration's plan to launch a three-year pilot scheme starting from the 2008-2009 financial year to provide five health care vouchers of $50 each to senior citizens aged 70 or above annually to partially subsidise their use of primary care services in the private sector. These elders could use the vouchers for services provided by western medicine doctors, Chinese medicine practitioners, allied health professionals and dentists, etc. and for preventive as well as curative services. The pilot scheme, costing some $150 million annually, would implement the "money follows patient" concept on a trial basis, enabling senior citizens to choose their own primary health care services in their own communities that suit their needs most, thereby piloting a new model for subsidised primary care services in the future. The Panel held discussions with the Administration on the pilot scheme on 12 October and 12 November 2007, and 14 April 2008.

14. Members urged the Administration to lower the eligible age for receiving health care vouchers to age 65 or above, having regard to the fact that the eligible age for receiving Old Age Allowance was between 65 and 69. The Administration explained that as the pilot scheme to implement the "money follows patient" concept was new, it was necessary to proceed with caution by confining the scheme to a smaller population group at the outset. Moreover, overseas experience had shown that private health care providers might increase their fees and charges if the government provided substantial subsidies for private health care services on a large scale.

15. Members were generally of the view that providing each senior citizen with five health care vouchers valued at $250 annually was too miserly, and should be increased to better safeguard the health of the elderly. In particular, Hon Andrew CHENG urged the Administration to increase the value of each

voucher to $120-$150, which was the average consultation and medication fee charged by doctors in the private sector, so that the elderly did not have to fork out their own money to foot their medical bills. The Administration explained that the health care vouchers were not meant to provide full subsidy for seeking health care services in the private sector, but to provide partial subsidy with a view to promoting the concept of shared responsibility for health care amongst patients and especially the concept of co-payment to ensure appropriate use of health care. It, however, pointed out that existing public health care services available to the elders would not be reduced as a result of implementation of the pilot scheme. Senior citizens might still access public health care services as necessary.

16. Dr Hon KWOK Ka-ki was of the view that the health care vouchers should at least afford each senior citizen to undergo annual physical and dental checkups. Dr Hon Joseph LEE suggested allowing health care vouchers to be used on purchasing physical checkup service provided by health centres run by non-governmental organisations and dental checkup service provided by Government dental clinics, while Hon Vincent FANG suggested designating one of the five health care vouchers for physical checkup.

17. The Administration advised that it attached great importance to strengthening preventive care for the elderly. Options on how best to take this forward should be discussed in the context of the territory-wide consultation on health care reforms and supplementary financing arrangements. It further advised that as the scheme of providing health care vouchers to the elderly was new, decision was made not to attach too many conditions on the usage of the vouchers during the three-year trial period to make the scheme more convenient for elders. Although the pilot scheme would be subject to a full review after the three-year trial period, a periodic review would be conducted every six months to fine-tune the scheme in light of operational experience.

18. Hon Mrs Selina CHOW asked whether there was any measure to prevent participating healthcare providers from charging users of the vouchers a fee higher than people who did not use the vouchers to pay the bill. The Administration advised that participating healthcare providers were not required to inform the Department of Health (DH) the fees they charged for their services. However, as these providers would not provide services exclusively for elders participating in the Scheme, it would be difficult for them to raise fees only for elders with vouchers. Nevertheless, a review would be conducted to see whether the situation cited by Mrs CHOW did occur, and if so, appropriate follow-up action would be taken.

19. Members urged the Administration to speed up the development of the electronic health care voucher system, so that the pilot scheme could be implemented before the first quarter of 2009. The Administration explained that the reason for setting the date of launching the pilot scheme in the first quarter of 2009 was to allow

time for eligible healthcare providers to register with DH and for DH staff to train participating providers on the use of the electronic health care voucher system. To protect the privacy of the personal data stored in the electronic health care voucher system, the Administration had exchanged views with the Privacy Commissioner for Personal Data on the electronic health care voucher system, especially in respect of protection of personal data. An external consultant would be engaged to conduct an assessment on the privacy impact and security of the electronic health care voucher system.

20. The Panel passed a motion requesting the Administration to provide health care vouchers to elders aged 65 or above, increase the value of each health care voucher to at least $100, expedite the launching of the health care voucher pilot scheme within 2008, and provide each senior citizen with at least 10 health care vouchers a year.

Allocation of resources among hospital clusters by the Hospital Authority

21. The Panel met with deputations and the Administration in January 2008 to discuss the principles and mechanism of resource allocation among hospital clusters by the Hospital Authority (HA).

22. Members urged HA to address the uneven allocation of resources among/within clusters, as evidenced by the serious deprivation of resources in the Kowloon East Cluster, the New Territories East Cluster and the New Territories West Cluster.

23. HA advised 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. 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. If it was revealed that secondary hospitals had been historically disadvantaged, action would be taken to increase resources to these hospitals progressively. 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 within 2008 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.

24. In response to members' enquiry on whether HA had any plan in hand to ensure the provision of adequate healthcare services in rapidly developing areas such as Tin Shui Wai, HA advised that 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.

25. Dr Hon YEUNG Sum was of the view that the merits of the clustering arrangements of public hospitals could not be fully realised without changing the existing management structure and culture in HA, such as the permanent appointment of Cluster Chief Executives (CCEs), which had given rise to inequity in the allocation of resources among/within clusters. An independent expert committee comprising all stakeholders was urged to be set up to undertake a comprehensive review of the clustering arrangement of HA hospitals and submit periodic reports to the Panel. HA did not see the case for the suggestion as the HA Cluster Review Panel 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 in February 2008. HA would be happy to organise a meeting for deputations attending the meeting to meet with the Cluster Review Panel. Moreover, the Administration would follow-up with HA on the suggestions regarding the appointment of CCE and Hospital Chief Executive, as well as the findings and recommendations of the review by HA on the clustering arrangement of public hospitals.

Doctor Work Reform Recommendation Report

26. HA established the Steering Committee on Doctor Work Hour in October 2006 to formulate strategies and implementation plans to reduce in three years the working hours of doctors of public hospitals to a level not exceeding 65 hours per week, and to reduce the excessively long continuous working hours of doctors to a reasonable level.

27. Members considered it unreasonable for HA to set the average weekly work hours of HA doctors at 65 hours, having regard to the fact that the average weekly work hours of doctors in many developed economies only ranged between 44 to 48 hours. HA clarified that reducing doctors' weekly work hours to not more than 65 hours should not be construed as making 65 hours a standard work week for doctors. Rather, it was an initial target which HA strived to achieve by the end of 2009, having regard to the phenomenon revealed in a local survey on doctors' work hours conducted in September 2006 that about 18% of all HA doctors were working for more than 65 hours in a week.

28. Hon Audrey EU suggested stipulating standard weekly work hours for public hospital doctors, as had been done in many developed economies. HA pointed out that due to differences in the working conditions among clinical specialties, it would not be practicable to establish standard work hours for all HA doctors.

29. Members pointed out that merely changing doctors' work pattern without providing additional funding could not bring about marked reduction in doctors' work hours, as the root of the problem lay in rising service demand, shortage of manpower, and significant public-private imbalance in the healthcare system.

30. HA recognised that measures to re-engineer the existing work procedures could not by themselves resolve the issues relating to doctors' long work hours and excess workload. However, given that manpower resources could not be made available overnight and lead time was required to produce medical graduates, reform in both service mode and doctors work patterns were necessary to ensure sustainable and quality patient care services in public hospitals. To tackle the problem of shortage of doctors, the Administration had already conveyed HA's projected manpower requirement on medical graduates to the University Grants Committee for consideration of a possible increase in the number of places of medical programmes funded by the Government. In terms of funding support to HA, an additional recurrent funding of $300 million had been provided to HA in 2006-2007 and 2007-2008 respectively. To support new initiatives of HA, funding allocation to HA in 2008-2009 would further increase by over $780 million, representing an increase of 2.6%. 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. In 2007-2008, around $500 million had been allocated to HA for replacement of equipment. The Administration would continue to liaise with HA on its resource requirement for meeting service needs and implementing new initiatives, including those relating to the doctor work reform.

31. Members were also advised that in order to address the brain drain of HA doctors, a new career and pay structure for doctors was implemented in October 2007. In particular, the pay point for new doctors had been raised by three pay points to attract new comers, the salary of serving doctors who joined HA after April 2000 had a pay rise of 15% to 38%, and the ceiling of Residents' pay scale had been lifted by eight pay points with a view to retaining specialists in the public hospital system. Besides, doctors who had passed specialist examinations would be granted pay increments, and HA would offer a nine-year employment contract to retain doctors undergoing specialist training. HA would continue to explore means to promote public-private partnership in the provision of services to better channel service demand to the private sector, thereby reducing the burden on the

public sector. The initiatives along this direction included employing part-time private practitioners to relieve the outpatient workload, purchasing primary care services from the private sector in Tin Shui Wai North, and the provision of subsidies to patients to undertake cataract surgeries in the private sector.

Vaccination policy

32. Members were briefed by the Administration in June 2008 on the latest position of the Administration's work to update the Childhood Immunisation Programme (CIP) and the Government Influenza Vaccination Programme (GIVP). In keeping with the recent developments in childhood vaccines not covered by the CIP, the Centre for Health Protection (CHP) of DH had commissioned in 2006, via the Research Council of the Research Fund for the Control of Infectious Diseases (RFCID), a local university to carry out a study to investigate the cost-benefit and cost-effectiveness of incorporating four childhood vaccines (pneumococcal conjugate vaccine, chickenpox vaccine, *Haemophilus influenzae* b vaccine, and hepatitis A vaccine) into the CIP. The university had submitted the results of the study which were being reviewed by the Research Council of the RFCID. Having regard to the findings of the study and the recommendations of the Scientific Committee on Vaccine Preventable Diseases (SCVPD) set up under the CHP, the Government would determine whether changes should be made to the CIP in the near future. As regards the GIVP, the SCVPD had finalised its influenza vaccination recommendations for the 2008-2009 season to, amongst others, extend to children aged from two to five years for reduction of hospitalisation.

33. In response to members' enquiries on when the CIP would be updated to incorporate the four childhood vaccines stated in paragraph 32 above, the Administration advised that it should come to a decision in the next few months. The Administration assured that the complexity of the logistical arrangements concerned and costs would not be factors for not incorporating the four childhood vaccines into the CIP, if the incorporation was recommended by the SCVPD.

34. Members welcomed the Administration's plan to provide a subsidy to children aged between six months and five years for getting influenza vaccinations from private doctors. Dr Hon YEUNG Sum opined that the pricing of private vaccination services should be transparent and reasonable, so as to enable the public to make an informed choice. The Administration agreed, and further advised that participating private doctors would be required to keep proper record of vaccination statistics and share them with the Government for surveillance purpose.

35. Members were of the view that the Administration should provide free influenza vaccinations to all elders aged 65 or above, regardless of whether they lived in residential care homes, who were chronically-ill or on public assistance. They considered the Administration's view that elders could use the health care vouchers to purchase private vaccination services unreasonable, as the total value of the vouchers at $250 a year was barely enough for elders to make two visits to a private doctor.

36. The Panel passed a motion urging the Administration to incorporate the pneumococcal conjugate vaccine, chickenpox vaccine, *Haemophilus influenzae* b vaccine, and hepatitis A vaccine into the CIP, make public the report to investigate the cost-benefit and cost-effectiveness of incorporating the aforesaid four childhood vaccines into the CIP, and put in place a review mechanism to ensure that the CIP kept up with the latest developments in childhood vaccines.

Other matters discussed

37. Other subject matters discussed by the Panel included mental health policy, review of HA's obstetric package charge for non-eligible persons, promotion of healthy eating in restaurants, surveillance of communicable diseases in Hong Kong, progress on registration of Chinese medicine practitioners, HA sentinel event policy, review of HA's private patient revenue management system and the pilot project to purchase primary care services from the private sector in Tin Shui Wai.

38. The Panel was consulted on the Administration’s proposals on the provision of general out-patient clinic in Tin Shui Wai Area 109, expansion of Tseung Kwan O Hospital, and commencement of certain sections of Chinese Medicine Ordinance (Cap. 549) governing the control over the possession, sale, import and export of Chinese herbal medicines and over the manufacture, sale by way of wholesale, import and export of proprietary Chinese medicines.

39. From October 2007 to June 2008, the Panel held a total of 16 meetings.

Council Business Division 2
Legislative Council Secretariat
27 June 2008

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 2007 - 2008 session

Chairman	Hon LI Kwok-ying, MH, JP
Deputy Chairman	Dr Hon Joseph LEE Kok-long, JP
Members	Hon Fred LI Wah-ming, JP
	Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP
	Hon CHAN Yuen-han, SBS, JP
	Hon Mrs Sophie LEUNG LAU Yau-fun, GBS, 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
	(Total : 13 Members)
Clerk	Miss Mary SO
Legal adviser	Mr Stephen LAM
Date	11 October 2007