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LC Paper No. CB(2)593/08-09
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 10 November 2008, at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, JP (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon Fred LI Wah-ming, JP Hon Andrew CHENG Kar-foo Hon Albert CHAN Wai-yip Hon Audrey EU Yuet-mee, SC, JP Hon Vincent FANG Kang, SBS, JP Hon Alan LEONG Kah-kit, SC Hon Cyd HO Sau-lan Hon CHAN Hak-kan Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou
Public Officers attending	:	Item III only Dr York CHOW, SBS, JP Secretary for Food and Health Mr Thomas CHAN Deputy Secretary for Food and Health (Health) 2 Dr Regina CHING, JP Assistant Director of Health (Health Promotion) Dr Emily LEUNG Principal Medical and Health Officer (3) Department of Health

Items III - V

Prof Gabriel M LEUNG, JP
Under Secretary for Food and Health

Items III - IV

Dr Beatrice CHENG
Chief Manager (Cluster Performance)
Hospital Authority

Item IV only

Mr Patrick NIP, JP
Deputy Secretary for Food and Health (Health)1

Dr W L CHEUNG
Director (Cluster Services)
Hospital Authority

Ms Ivis CHUNG
Chief Manager (Allied Health) (Deputising)
Hospital Authority

Item V only

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

Dr F C PANG
Deputising Chief Manager (Quality & Standards)
Hospital Authority

Dr T H LEUNG
Head, Surveillance & Epidemiology Branch
Centre for Health Protection
Department of Health

Ms Eliza YAU
Principal Assistant Secretary for Food and Health
(Food & Health) Special Duties

Dr Liza TO May-kei
Principal Medical & Health Officer for Food and Health
(Food & Health) Special Duties

Clerk in attendance	:	Miss Mary SO Chief Council Secretary (2) 5
Staff in attendance	:	Ms Maisie LAM Council Secretary (2) 2 Ms Sandy HAU Legislative Assistant (2) 5

Action

I. Information paper(s) issued since the last meeting
(LC Paper No. CB(2)172/08-09(01))

Members noted a submission dated 27 October 2008 from 香港兒童健康疫苗關注組 issued since the last meeting and did not raise any queries.

II. Discussion items for the next meeting
(LC Paper Nos. CB(2) 208/08-08(01) and (02))

2. Members agreed to discuss the following items at the next regular meeting to be held on 8 December 2008 -

(a) Advance directives in relation to medical treatment; and

(b) Towards quality patient care – effective incident reporting and complaint management in Hospital Authority (HA).

III. New campaign to promote organ donation
(LC Paper Nos. CB(2)208/08-09(03) and (04))

3. Secretary for Food and Health (SFH) briefed members on the launch of a new campaign to further promote organ donation amongst the public and enhance the recognition of organ donation as a charitable act to save the lives of others, details of which were set out in the Administration's paper (LC Paper No. CB(2)208/08-09(03)).

Promotion of organ donation

4. Ms Audrey EU said that despite the efforts made by the Administration over the years to promote organ donation, the number of people willing to donate their organs after death was still on the low side. Ms EU pointed out

Action

that one of the reasons why some people were hesitant in donating their organs after death was because they feared they would not be taken care of by medical personnel if they had an accident or suffering from acute illnesses after they had signed the organ donation card.

5. SFH assured members that this would never happen. Saving lives was the responsibility and foremost priority of every medical professional. Only after a patient was certified brain stem death would the suitability of organ donation be considered to bring new life to another patient with organ failure.

6. Ms EU further asked whether the Administration had conducted any study to find out the characteristics of people willing to donate organs after death, as such information, if available, would help to shed light on how the promotion campaign should be run to greater effect. Ms Cyd HO expressed views.

7. Assistant Director of Health (Health Promotion) (ADH(HP)) responded that organ donation was being gradually accepted by the community. A telephone interview conducted by the Department of Health (DH) in April last year revealed that about 70% of respondents were willing to donate their organs after death, as opposed to only 29% and 37% in 1992 and 1994, and that prospective donors tended to be younger, more educated, with females more than males. Based on these findings, the new promotion campaign on organ donation would focus on appealing to the working population, such as those working in private companies and non-governmental organisations (NGOs), and university and secondary school students.

8. Dr LEUNG Ka-lau considered it inconceivably low that the number of patients waiting for heart and lung transplant at public hospitals as at 31 December 2007 was only nine and two respectively. Dr LEUNG asked whether this was due to the lack of resources for carrying out heart and lung transplantation.

9. Chief Manager (Cluster Performance), Hospital Authority (Chief Manager (CP), HA) responded that the reason why the number of patients waiting for heart and lung transplant was small was primarily due to the fact that heart and lung donors were scarce. For various reasons, many deceased donors' families refused to consent to heart and lung donation. Even if the deceased's families gave consent, the donor and receipts' heart/lung needed to be sized matched. Because of the scarcity of organs and lack of medical means to maintain the lung/heart function for end-staged lung/heart diseases, many patients died while waiting.

10. Dr PAN Pey-chyou said that to better promote organ donation, consideration should be given to instilling in youths that organ donation was a charitable life-saving act through civic education in schools; making the new promotion campaign more family-centred, given the importance of family's

Action

acceptance; disseminating organ donation message in hospitals/clinics; giving out inexpensive souvenirs to people registered to donate organs after death; and encouraging television stations to spread the organ donation message in their programmes.

11. Mr Andrew CHENG shared Dr PAN's views that the promotional efforts on organ donation should be made more family-centred. Mr CHEUNG suggested that the Administration should collaborate with, say, NGOs, in making home visits to garner family's acceptance of organ donation. Mr CHENG further said that another way to get more people to sign up as prospective donors was to publicise the long waiting list for transplant.

12. Mr Alan LEONG suggested rallying the support of social groups, such as university students, who had registered their wish to donate organs after death to promote organ donation amongst their peers, and launching a donor recognition scheme to honour the charitable act of organ donation.

13. SFH responded that the new campaign to promote organ donation was aimed at reaching different sectors of the community. For instance, DH would collaborate with schools and educational institutions to organise exhibitions and seminars to enlist the support of students to further garner support for organ donation in the community; arrange for organ donation pamphlets to be distributed through utility bills in order to reach every household in the community and appeal to social leaders, including Members of the Legislative Council (LegCo), to express support for organ donation. Notwithstanding, the Administration welcomed all possible ideas of further promoting organ donation in the community.

14. Ms Cyd HO questioned the effectiveness of the new organ donation promotion campaign, as its content was no different from that of the previous campaigns.

15. SFH responded that the main strategy for the new promotion campaign was to tie in with the launch of Centralised Organ Donation Register (CODR) on 24 November 2008 to instil actions in the community through engaging community leaders and different sectors of society so as to garner their support and through them reach out to the public. The development of the CODR was to provide an easily accessible means for individuals to voluntarily register their wish to donate organs after death. Even with the CODR, signing and carrying organ donation cards would remain an option for individuals to express their wish, but the CODR would provide the added benefits that their wish would be readily available to Transplant Co-ordinators at the critical moment.

16. Mr Albert HO cited a recent case whereby the wish of a dying patient to donate organs after death was denied by public hospital staff with no reasons given. Mr HO said that if this was the attitude of healthcare staff in handling

Action

the wish of prospective donors, all efforts made to promote organ donation would be wasted.

17. Chief Manager (CP), HA responded that the reason why the hospital staff turned down the wish of the potential donor to donate organs after death was because the patient had potential medical contra-indication including infection risks for organ / tissue donation. Regrettably, this was not communicated clearly to the potential donor's family members. To prevent similar incident from recurring, HA would step up work on enhancing the communication skills of hospital staff on handling organ donation.

Operation of the CODR

18. Ms Audrey EU asked -

(a) what measures would be adopted to ensure the authenticity of the person wishing to donate his organs after death through registering in the CODR online; and

(b) whether prospective donors would need to re-register in the CODR every year; and

(c) whether prospective donors could amend the organs they wished to donate after death after registration.

19. ADH(HP) responded as follows -

(a) upon receiving the organ donation form, DH staff would contact the prospective donor by telephone to verify his/her personal particulars;

(b) there was no need for prospective donors to re-register after registration; and

(c) prospective donors might request to amend or withdraw their registration through application to DH.

20. Dr PAN Pey-chyou enquired about the viability of merging the CODR with HA's electronic patient records to increase the rate of successful organ donation.

21. SFH responded that all collected data in the CODR would be classified as personal and treated with strict confidentiality so that only persons authorised by DH would have access to the CODR.

22. Mr Andrew CHENG noted that building on the experience of Organ Donation Register set up by the Hong Kong Medical Association (HKMA) to

Action

store the consent of some 40 000 prospective donors, DH had developed the CODR in collaboration with HKMA. Mr CHENG asked whether the consent stored in HKMA's Organ Donation Register would be transferred to the CODR.

23. ADH(HP) responded that HKMA would be sending out letters in batches to seek the consent of their registrants on transferring their personal data and declared wish to the CODR.

Other issues

24. Mr Albert CHAN said that to ensure that the wish of prospective donors was followed, Transplant Co-ordinators of HA should not be required to seek consent from family members about donating their relatives' organs if their relatives had registered in the CODR or had signed the organ donation card whilst they were alive.

25. SFH responded that Transplant Co-ordinators would exercise their professional judgment, should the wish of family members contradict that of the deceased to donate organs. It should, however, be pointed out that family members would usually respect the wish of the deceased if the deceased had made known their wish to donate organs.

26. Mr Albert CHAN asked whether the organs of a person who died overseas could be brought into Hong Kong by their family members to realise the deceased's wish to donate organs. In response, SFH said that it would be difficult, if not impossible, to do so as many overseas places did not permit exportation of human organs on an individual's basis.

Conclusion

27. In closing, the Chairman urged the Administration to ensure the confidentiality and security of data stored in the CODR and enhance the effectiveness of the new promotion campaign on organ donation.

IV. Grant for the Samaritan Fund

(LC Paper Nos. CB(2)208/08-09(05) and (06))

28. Under Secretary for Food and Health (USFH) briefed members on the Administration's proposal for a one-off grant of $1 billion to the Samaritan Fund (the Fund) to meet the Fund's projected funding requirements up to 2012, details of which were set out in the Administration's paper (LC Paper No. CB(2)208/08-09(05)). Subject to members' support, the Administration would seek funding approval from the Finance Committee of LegCo on 12 December 2008.

Action

29. Mr CHAN Hak-kan asked why the financial assessment for the Fund was based on a household basis. Mr CHAN cited a case whereby a leukemia patient was no longer eligible for financial assistance under the Fund after he moved in with his parents.

30. USFH responded that the practice of using the patient's household income in assessing the level of subsidy granted under the Fund was in line with other safety nets funded by public money, such as public housing, student loans, legal aid and Comprehensive Social Security Assistance (CSSA). Such assessment criterion for public assistance was also adopted in many developed countries overseas. USFH further said that the rationale of using the applicant's household income in assessing the level of subsidy granted was to encourage family members to support each other and to prevent the avoidance of responsibility by resorting to public assistance in the first instance.

31. As regards the leukemia patient mentioned by Mr CHAN in paragraph 29 above, USFH said that the Medical Social Workers (MSWs) concerned were still considering whether subsidy under the Fund should continue to be provided to the patient, and if so, the amount. In vetting patients' application for the Fund, MSWs would, apart from adopting the financial criteria as set out in paragraphs 6-7 of the Annex to the Administration's paper, also take into account non-financial factors, such as whether the patient had other medical expenses, was a single-parent, or had a disabled or chronically-ill family member, where appropriate.

32. Ms Audrey EU expressed support for the proposed grant of $1 billion to the Fund. Ms EU, however, held the view that long term funding arrangement for the Fund should be hammered out expeditiously, having regard to rapid advancement in medical technologies and the ageing population. In the light of this, Ms EU suggested making patient's expenditure on self-financed drug items and non-drug items tax deductible.

33. Dr PAN Pey-chyou also asked whether the Administration had a concrete plan on the long term funding arrangement for the Fund.

34. USFH responded that long term funding arrangement for the Fund would be examined in the context of health care financing. The Government planned to draw up details of service reform and supplementary financing with the aim to initiate the second stage public consultation in the first half of 2009. It would be more appropriate to discuss Ms Audrey EU's suggestion then.

35. Mr Fred LI queried whether the Fund still served its intended purpose of providing relief to needy patients. Mr LI pointed out that the decisions to introduce drugs into the HA Drug Formulary (HADF) and to categorise drugs as self financed items (SFI) for support by the Fund, and the management of the Fund were all by HA.

Action

36. USFH responded that since its establishment in 1950, the Fund had never deviated from its objective of providing relief to needy patients to meet expenses on privately purchased medical items or new technologies in the course of medical treatment which were not covered by hospital maintenance fees or outpatient consultation fees in public hospitals/clinics.

37. USFH further said that the determination of which new drugs should be included into HADF and which new drugs should be categorised as SFI for support by the Fund were subject to checks and balances. The Drug Advisory Committee of HA appraised new drugs for inclusion into HADF on the basis of clinical efficacy, safety and cost effectiveness to ensure rational use of finite resources and provision of effective treatment to patients. Similar evaluation criteria were adopted by the Drug Utilisation Review Committee of HA (DURC) in its periodic review on existing drugs included in HADF. The DURC would also advise the Fund at the beginning of each year on the potential list of SFI drugs to be supported by the Fund. The DURC recommendations would be considered by the Samaritan Fund Management Committee, which in turn would make recommendations to the Medical Services Development Committee (MSDC) of HA Board, which was chaired by a HA Board member. USFH assured members that introduction of drugs, including SFI drugs, into HADF would foremost be based on the efficacy and safety of the drugs and not their cost. This was to safeguard patients' health, as past experience in US showed that some new drugs had been found to have adverse health impact three to five years after they had been used on patients and were required to be recalled from the market.

38. Mr Andrew CHENG expressed concern that the Fund was used as a justification for HA to not include drugs proven to be of significant benefits but extremely expensive to provide. Mr CHENG pointed out that privately purchased drugs proven to be of significant benefits, such as Glivec, and privately purchased medical items no longer considered new technologies, such as Percutaneous Transluminal Coronary Angioplasty, were still not provided by HA as part of its subsidised services.

39. Director (Cluster Services) HA responded that there were cases of privately purchased drug and non-drug items now being provided by HA as part of its subsidised services. For instance, artificial heart valves, some SFI drugs including Paclitaxel for treatment of breast cancer, a drug for renal patients, and an antifungal drug had been included in HADF as special drugs. USFH also said that needy patients who were not on CSSA might seek fee waiver from HA. Under HA fee waiver mechanism, patient might be provided with one-off full or partial waiver for a major operation or for purchasing an expensive medical item, and/or period waiver for medical fees which was renewable.

Admin

40. At the request of Mr Andrew CHENG, Director (Cluster Services) HA undertook to provide information on items that had been removed from the

Action

categories of self-financed items under coverage of the Fund for inclusion in the standard subsidised public services over the years.

41. Whilst supporting the proposed grant of $1 billion to the Fund, Mr Albert HO said that the existing arrangements of deciding which drugs should be included in HADF and categorised as SFI drugs needed to be re-examined to better provide relief to needy patients not on CSSA. Ms Cyd HO expressed similar views.

42. USFH responded that the fact that patients could not afford SFI drugs did not mean that they would be deprived of proper care. All drugs included in HADF were proven to be effective and safe.

43. Dr LEUNG Ka-lau declared that he was HA employee. Dr LEUNG said that the existing procedures for introducing new drugs into HADF were too bureaucratic and had resulted in Hong Kong lagging behind many developed countries in providing new drugs to patients. Dr LEUNG further said that HA should let frontline doctors decide which drugs to be provided to patients, regardless of whether the drugs were included in HADF.

44. USFH responded that the development of HADF was in line with practice adopted by many overseas countries in developing their national list of essential medicines, taking into account their disease prevalence, available evidence on efficacy and safety, and comparative cost effectiveness. USFH further said that the development of HADF would not result in Hong Kong not able to gain access to new drugs. So long as the new drug had obtained the necessary approval from the authority concerned, the drug could be registered in Hong Kong for sale to patients, albeit these drugs might not be provided at public hospitals/clinics in the first instance for the reason already given in paragraph 37 above. On letting HA doctors decide which drugs to prescribe to patients, USFH said that HA doctors would use their professional judgement to decide whether first-line drugs or second-line drugs, i.e. general drugs and special drugs under HADF, should be used to treat patients, as well as non-standard drugs categorised as SFI at the request of patients.

45. In closing, the Chairman said that members were supportive of the proposed one-off grant of $1 billion to the Fund.

V. Health aspect of melamine-tainted milk powder and dairy products

(LC Paper Nos. CB(2)208/08-09(07) and CB(2)101/08-09(01))

46. Members noted the Administration's paper (LC Paper No. CB(2)208/08-09(07)) detailing the measures and actions taken by the Administration to provide health services and safeguard public health in response to the detection of melamine in milk power and diary product, and the Report of the Expert Group on Melamine Incident (LC Paper No. CB(2)101/08-09(01)).

Action

47. Ms Audrey EU noted that one of the five areas covered by the terms of reference of the Expert Group on Melamine Incident (the Expert Group) was to assess the impact of the incident and ensure effective monitoring and inspection on dairy products and related food in order to protect the health of citizens. Ms EU asked whether the food types under the purview of the Expert Group only covered those with milk content.

48. Mr Andrew CHENG hoped that the scope of surveillance by the Expert Group would extend to food products commonly consumed by adults.

49. USFH responded that as the Expert Group was formed in the wake of the discovery of melamine in infant formula produced in the Mainland in early September 2008, it was natural that the scope of work of the Expert Group was on dairy and milk products. However, in light of the progress and testing results, the Expert Group had recommended that the scope of testing should cover food products with no milk content but might be subject to melamine contamination to ensure food safety for the people of Hong Kong. USFH further said that in the first round of the surveillance, the Centre for Food Safety (CFS) had tested 161 egg samples for melamine, i.e. 100 from the Mainland and 61 from other places outside Hong Kong. Only three egg samples from the Mainland (one from Liaoning Province and two from Hubei Province) were detected with melamine exceeding the legal limit, whereas all of the 100 egg samples from other places were satisfactory. CFS had also tested 21 marine fish samples, 77 freshwater fish samples, 18 chilled chicken samples and six chilled pork samples for melamine, the results of which were all satisfactory. CFS had embarked on its second round of surveillance to cover testing on animal feed and frozen meat, amongst others.

50. Ms Cyd HO said that the membership of the Expert Group should include persons representing the interests of Hong Kong born children living in the Mainland.

51. USFH responded that the Immigration Department maintained close contact with Food and Health Bureau on a daily basis on the number of Mainland children aged below 11 who were re-entry permit holders. Although the capacity of each HA Designated Clinic (DC) and Special Assessment Centre (SAC) was handling some 50 cases a day, some DCs/SACs located in the New Territories had handled over 100 cases a day at the early phase of the setting up of the 18 DCs and seven SACs on 23 September 2008 to provide free assessment for eligible children aged 12 or below. Although the DCs and SACs had reverted to its normal operating hours, the demand would be closely monitored and the operating hours adjusted if the demand warranted increased service. The DCs and SACs would be in operation for at least six months until March 2009 in the light of actual needs so as to ensure that the service demands were well met.

Action

52. The Chairman enquired about the number of Hong Kong born children living in the Mainland who had visited the DCs and SACs.

53. Director (Quality & Safety), HA responded that at the beginning HA staff had tried to ask the parents who brought their children to the DCs and SACs for health assessment where the children lived, but eventually gave up asking the question as most respondents only gave their addresses in Hong Kong. HA considered it more important to find out which eligible children were suffering from renal problems after consuming melamine contaminated milk products, regardless of where they lived.

54. In response to Mr Albert CHAN's comments that the Administration had acted too slowly in tackling the melamine incident, USFH said that immediately after learning about the incident that some infant formulae manufactured in the Mainland were found to contain melamine on 11 September 2008, samples of dairy products were taken on 12 September 2008 for testing on the following day.

55. Dr PAN Pey-chyou noted from paragraph 9(d) of the Report of the Expert Group that CFS would closely monitor international developments in the setting of standards for melamine analogues. Dr PAN asked the progress made in this respect.

56. USFH responded that a working group chaired by him, and comprised representatives of the Government Laboratory and two universities, had been set up to closely monitor international developments in the setting of standards for melamine analogues. Research projects in this regard were being planned.

Admin 57. In closing, the Chairman requested HA to provide the total number of assessment and follow-up treatment services provided by the DCs and SACs since 23 September 2008, and daily updates on the services of the DCs and SACs.

VI. Any other business

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

Council Business Division 2
Legislative Council Secretariat
6 January 2009