立法會
Legislative Council

LC Paper No. CB(2)1440/10-11
Ref : CB2/PL/HS
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 14 March 2011, at 8:30 am
in Conference Room A of the Legislative Council Building

Members present :
Dr Hon LEUNG Ka-lau (Chairman)
Hon Albert HO Chun-yan
Hon Fred LI Wah-ming, SBS, JP
Hon CHEUNG Man-kwong
Hon Andrew CHENG Kar-foo
Hon LI Fung-ying, SBS, JP
Hon Audrey EU Yuet-mee, SC, JP
Hon CHAN Hak-kan
Hon CHAN Kin-por, JP
Hon CHEUNG Kwok-che
Dr Hon PAN Pey-chyou
Hon Alan LEONG Kah-kit, SC
Hon Albert CHAN Wai-yip

Members absent :
Dr Hon Joseph LEE Kok-long, SBS, JP (Deputy Chairman)
Ir Dr Hon Raymond HO Chung-tai, SBS, S.B.St.J., JP
Hon Cyd HO Sau-lan
Hon IP Kwok-him, GBS, JP

Public Officers attending :
Items V to VII

Dr York CHOW Yat-ngok, GBS, JP
Secretary for Food and Health

Items V and VI only

Mr Chris SUN
Principal Assistant Secretary for Food and Health (Health) 3

Item V only

Mr Thomas CHAN, JP
Deputy Secretary for Food & Health (Health)2

Dr Shirley LEUNG
Assistant Director of Health (Family and Elderly Health Services)

Dr Patrick CHONG
Senior Medical & Health Officer (Health Care Voucher)
Department of Health

Item VI only

Dr Regina CHING, JP
Assistant Director of Health (Health Promotion)

Dr Beatrice CHENG
Advisor, Hospital Authority Transplant Services

Item VII only

Mrs Susan MAK
Deputy Secretary for Food and Health (Health) 1

Mr Stephen SUI
Commissioner for Rehabilitation
Labour and Welfare Bureau

Mrs Cecilia YUEN
Assistant Director of Social Welfare
(Rehabilitation and Medical Social Services)

Dr W L CHEUNG
Director (Cluster Services)
Hospital Authority

Ms Margaret TAY
Chief Manager (Integrated Care Programs)
Hospital Authority

Clerk in attendance : Ms Elyssa WONG
Chief Council Secretary (2)5

Staff in attendance : Ms Maisie LAM
Senior Council Secretary (2)5

Ms Sandy HAU
Legislative Assistant (2)5

Item IV only

Ms Clara TAM
Assistant Legal Adviser 9

Item VII only

Mr Watson CHAN
Head of Research Division

Ms Ivy CHENG
Research Officer 6

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I. Confirmation of minutes
(LC Paper No. CB(2)1219/10-11)

The minutes of the meeting held on 14 February 2011 were confirmed.

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

2. No information paper was issued since the last meeting.

III. Items for discussion at the next meeting
(LC Paper Nos. CB(2)1220/10-11(01) and (02))

3. Members agreed to discuss the item "Issues relating to the wastage of doctors in the Hospital Authority" proposed by Dr PAN Pey-chyou at the next regular meeting scheduled for 11 April 2011 at 8:30 am. Members further agreed that the referral from the Legislative Council Members' meeting with the Eastern District Council members regarding the shortage of healthcare practitioners in public hospitals would be discussed in the context of the above item.

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4. Members also agreed to discuss the following items proposed by the Administration at the next regular meeting -

(a) Creation of new directorate posts in the Department of Health; and

(b) Progress of hospital accreditation in public hospitals.

IV. Proposal to appoint a subcommittee to study issues relating to the registration of proprietary Chinese medicines
(LC Paper No. CB(2)1220/10-11(03))

5. The Chairman said that at the meeting on 14 February 2011, members agreed that the Panel should appoint a subcommittee to study issues relating to the registration of proprietary Chinese medicines. The proposed terms of reference, work plan and time frame of the subcommittee prepared by the Legislative Council Secretariat were set out in LC Paper No. CB(2)1220/10-11(03) for members' consideration. The Clerk drew members' attention to Rule 26 of the House Rules regarding activation of subcommittees on policy issues. Since more than eight subcommittees on policy issues were already in operation, the subcommittee to be appointed by the Panel would be put on the waiting list.

6. Members agreed to the proposed terms of reference, work plan and time frame of the subcommittee. Members further agreed to seek the approval of the House Committee for activation of the subcommittee at its meeting to be held on 18 March 2011.

7. The Chairman said that subject to the House Committee's decision, the Panel would discuss at the next regular meeting whether issues relating to the registration of proprietary Chinese medicines should be followed up by the Panel in May 2011 pending the activation of the subcommittee.

V. Interim review of Elderly Health Care Voucher Pilot Scheme
(LC Paper Nos. CB(2)1220/10-11(04) and (05); CB(2)1221/10-11(01) and (02) and CB(2)1274/10-11(01))

8. Secretary for Food and Health ("SFH") briefed members on the findings of the interim review of the Elderly Health Care Voucher Pilot Scheme ("the Scheme") launched on a pilot basis for three years from 1 January 2009 and the Administration's proposal to extend the Scheme for another three years (from 1 January 2012 to 31 December 2014) with an

increase in the value of health care vouchers per year from $250 to $500 and improvements to the operational aspects of the Scheme, details of which were set out in the Administration's paper (LC Paper No. CB(2)1220/10-11(04)).

Scheme participation and utilization

9. Mr Fred LI expressed concern that as at end 2010, only 57% of the eligible elderly population had registered with the Scheme and only 45% had made voucher claims. He considered that the low enrolment rate of medical practitioners in the Scheme, particularly those with practices in the vicinity of public housing estates, was the main reason for the low take-up rate of the Scheme. Ms LI Fung-ying and Ms Audrey EU shared a similar view. Ms EU noted that the New Territories had relatively fewer enrolees when compared with other districts in Hong Kong. She urged the Administration to step up efforts in encouraging those healthcare service providers who practised in the New Territories to enrol in the Scheme.

10. SFH advised that an objective of the Scheme was to assess, among others, the acceptance level among the elderly towards private primary healthcare services and the capacity of the private healthcare system. Among the some 4 200 economically active medical practitioners in the private sector, 1 431 had enrolled in the Scheme with practices located in every district. The participation rate was on par with other public-private partnership scheme, which was not low in relative terms. Mr Fred LI held the view that it was not appropriate to compare the participation rate of medical practitioners in the Scheme with other public-private partnership schemes, as the user base of the Scheme was far greater than that of other schemes.

11. Dr PAN Pey-chyou noted that according to the opinion survey conducted by the medical school of the Chinese University of Hong Kong among elderly people, 64% of the interviewees perceived that health care vouchers were convenient to use, and 65% considered the Scheme useful. He sought explanation on the sampling methodology adopted by the study and the low registration and take-up rates of the Scheme since such a high satisfaction rating on the Scheme had been given by the elderly.

12. Deputy Secretary for Food & Health (Health)2 ("DSFH(H)") advised that the survey covered a sample population of more than 1 000 elderly people, comprising both voucher users and non-users, randomly drawn from the elderly population in the street and in clinics. Among them, 70% were aware of the Scheme. For those interviewees who were aware of the Scheme, the main reasons for not using the vouchers included:

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the healthcare service providers whom they usually visited had not enrolled in the Scheme; and they were used to seeing public doctors.

13. Noting only three proven cases of abuse of the Scheme so far which involved two medical practitioners and one Chinese medicine practitioner, Mr CHAN Kin-por asked about the measures put in place to prevent fraud and abuse. He further sought information on the number of healthcare service providers who had withdrawn from the Scheme and their reasons for withdrawal. Ms LI Fung-ying raised a similar question.

14. DSFH(H) and Senior Medical & Health Officer (Health Care Voucher), Department of Health ("SMHO(HCV), DH") responded as follows -

(a) in accordance with the terms of agreement, the two medical practitioners and one Chinese medicine practitioner referred to in paragraph 13 above had been disqualified from the Scheme and they were requested to return the funds disbursed for the concerned claims. The Department of Health ("DH") had also issued reminders to all enrolled healthcare service providers on proper procedures and documentation of voucher claims;

(b) a total of 202 healthcare service providers had withdrawn from the Scheme as at end 2010. It should be noted that the number of participating healthcare service providers had indeed recorded an increase during the two-year pilot period, as enrolment applications had outnumbered withdrawal cases. Among those withdrawn, most had not provided reasons for their withdrawal. For those who had, change of workplace was the most common reason;

(c) feedback collected from the healthcare service providers via the study conducted by the medical school of the Chinese University of Hong Kong revealed three reasons for non-enrolment: elderly people not being their main clientele; no computer in their clinics; and claim procedures were complex; and

(d) in the light of the problems encountered during the initial phase of the Scheme concerning the use of the electronic platform and the procedures for making claims, efforts had continuously been made over the past two years to streamline the operation details of the Scheme. For instance, starting from late 2010, enrolled healthcare service providers were

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provided with a Smart Identity Card Reader. This would obviate the need for them to manually input the voucher users' personal particulars into the eHealth System for voucher claims.

15. In response to Dr PAN Pey-chyou's enquiry about the increase in the number of enrolees since the introduction of the Scheme in January 2009, SFH advised that as at end of February 2011, a total of 2 780 healthcare service providers (i.e. 1 432 medical practitioners, 790 Chinese medicine practitioners, 243 dentists and 315 other healthcare professionals) had enrolled in the Scheme, with 3 508 places of practice covering the whole territory. At the request of Dr PAN, SFH agreed to provide after the meeting a breakdown by quarter of the number of new enrolments since January 2009.

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16. While not objecting to the proposal to include optometrists with Part I registration under the Supplementary Medical Professions Ordinance (Cap. 359) in the Scheme in the extended pilot period, Ms LI Fung-ying cast doubt about the extent to which the addition of optometrists could help address the healthcare needs of the elderly and promote the importance of preventive healthcare.

17. SFH advised that to forge closer collaboration with healthcare professionals to promote the importance of primary care and to encourage utilization and provision of such services, the Administration would promote, in partnership with interested and qualified healthcare service providers, a voluntary and protocol-based elderly health check programme at affordable prices for elderly people. Elderly people aged 70 or above could meet the payment, partly or wholly, through health care vouchers.

18. Noting that only 13% of the Chinese medicine practitioners had enrolled in the Scheme, Mr CHAN Hak-kan enquired whether the main reason for their non-participation was the lack of computer facilities in their clinics for accessing the eHealth System.

19. SFH advised that apart from the lack of computer facilities to access the eHealth System, some Chinese medicine practitioners indicated that the consultation fee they charged was already at a very low level and they did not intend to accept the health care vouchers.

20. Referring to the Hong Kong Medical Association's letter dated 25 January 2011 (LC Paper No. CB(2)1221/10-11(01)), Ms Audrey EU asked about the actions to be taken by the Administration to address the Association's concern about the inadequacy of the design of the eHealth

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System which allowed single instead of multiple entries of the "reason of visit" in each consultation. The Chairman raised a similar concern.

21. SFH responded that it would not be difficult for medical professionals to judge the primary reason of a patient visit. It would either be preventive care or management of acute episodic condition.

22. Mr CHEUNG Man-kwong asked whether consideration could be given to allowing eligible elderly people to redeem the health care vouchers if they could provide receipts for payment of fees charged by the private healthcare service providers, instead of requiring the service providers to enrol in the Scheme. This could address the shortcoming of the Scheme whereby elderly people tended not to use the vouchers if the medical practitioners whom they usually visited did not enrol in the Scheme.

23. SFH responded that the Administration had given thought to the arrangement suggested by Mr CHEUNG Man-kwong when designing the Scheme. Experience of overseas places revealed that this arrangement would entail increase of service volume and high administrative cost, but could not ascertain benefits to patients. SFH further pointed out that the enrolment of private healthcare service providers in the Scheme was necessary to facilitate the collection of information on the healthcare services provided by the enrolees to their voucher users so as to ensure that public money was used properly and effectively.

Value of the health care vouchers

24. Mr Fred LI considered that the Administration's proposal to increase the voucher value per year from $250 to $500 with effect from the extended pilot period was still inadequate to meet the healthcare needs of the elderly. Mr Alan LEONG shared a similar view.

25. SFH responded as follows -

(a) the Scheme aimed at encouraging the elderly to seek private primary healthcare services, in particular preventive care, in their neighbourhood through the provision of partial subsidy, with a view to improving the health of the elderly population and thereby reducing their reliance on public specialist out-patient services and hospital care. Having regard to the need to ensure the prudent and effective use of public money, the Administration needed to carefully consider whether, and if so, to what extent an increase in voucher amount would affect the

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healthcare seeking behaviour among elderly people, the prices to be charged by healthcare service providers, the amount elderly people were willing to co-pay and the emphasis elderly people put on preventive services;

(b) the usage statistics captured in the eHealth System during the pilot period showed that 75% of the voucher users tended to stay with the same medical practitioners, which was conducive to the development of continuous doctor-patient relationship. However, there was no evidence to show that the Scheme had brought about any noticeable changes in the healthcare seeking behaviour among the elderly, or resulted in an increase in the utilization and provision of preventive care services;

(c) while it was the Administration's hope that the coverage of the Scheme could be further expanded, the Administration needed to obtain more data to further test the effectiveness of the Scheme. The recommendation to increase the voucher amount by one-fold to $500 per year had therefore struck a right balance. The current flexibility in using health care vouchers would also be retained, i.e. no limit on the number of vouchers that might be used for each episode of healthcare services; no restriction on the type of healthcare services or providers for which each voucher might be used; and no limit on the amount of vouchers to be used for different types of healthcare services or providers; and

(d) to better assess the services provided to the voucher users and the impact of vouchers on the provision of primary care services, the Administration would explore the feasibility of requiring participating healthcare service providers to input more specific diagnosis information and the co-payment made by an elderly person for each consultation involving the use of the vouchers. The review of the effectiveness of the Scheme in the next three-year pilot period would thus provide an objective basis for future policy reviews.

26. Ms LI Fung-ying asked the Administration whether the proposed increase of the voucher value had taken into account the factor of medical inflation in the next three years.

27. SFH advised that according to the interim review, the average number of vouchers claimed per transaction was in the range of 2.5 to 2.7.

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Taking also into account the unlikelihood that the rate of medical inflation would be more than one fold for the next three-year pilot period, the current proposal to increase the voucher value from $250 to $500 per year with effect from the next pilot period should be sufficient to meet the healthcare service needs of the elderly and compensate for medical inflation. To assess whether users would truly benefit from the increase in the voucher value, the Administration would put in place measures as mentioned in paragraph 25 above to enable tracking of changes in co-payment made by voucher users to monitor whether a higher voucher value had led to an increase in consultation fees.

28. The Chairman sought information on the reasons for setting the subsidy level at $500 per year for the extended pilot period. In his view, any behavioural change on the part of elderly people in seeking private primary healthcare services could only be achieved when there was adequate financial incentive.

29. SFH explained that the Scheme aimed at providing partial subsidies for the elderly to receive private primary healthcare services in the community, as additional choices on top of the existing public primary healthcare services provided through the public general out-patient clinics ("GOPCs"). The value of the five health care vouchers was set at $50 each in 2009 on the basis of the Administration's finding that the average consultation fee charged by the medical practitioners practising in the vicinity of public housing estates stood at around $100 in 2009. The provision of a half-fare subsidy would enable elderly people to choose their own primary care service providers in their neighbourhood, thus obviating the need to travel across districts to the public GOPCs which might cost more than $100 for each episode (i.e. $45 consultation fee plus travelling expenses). In proposing a one-fold increase in the voucher value to $500 per year for the extended pilot period, the Administration had taken into consideration the possible consultation fee increases in the past two years and the usage statistics that the average number of vouchers claimed per transaction was in the range of 2.5 to 2.7. At the request of the Chairman, SFH undertook to provide a written explanation on the considerations for deciding the subsidy level of the Scheme.

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30. Mr Albert HO said that given the limited voucher value, there was no doubt that elderly people would save the use of the vouchers for the management of acute episodic condition. He asked the Administration whether consideration could be given to issuing an additional voucher to the elderly for the purpose of health check.

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31. SFH stressed that it was prudent for the Administration to rationally deploy the finite public resources to best serve the needs of the community and data was required to justify an increase in resource allocation. The Administration would take into account the usage statistics and members' views and suggestions when reviewing the effectiveness of the Scheme in the extended pilot period. Subject to the review, consideration might be given to revisiting some of the operational aspects of the Scheme. As mentioned earlier, efforts were being made to study the introduction of a voluntary, protocol-based and reasonably-priced health check programme for the elderly in the extended pilot period.

32. Ms Audrey EU suggested that consideration could be given to providing additional subsidy, say $200 per consultation, as an incentive for the elderly to seek dental check-up services.

33. SFH responded that elderly people were given full discretion and flexibility under the Scheme to decide which type of healthcare services for which each voucher might be used. The Administration would also launch a pilot project to provide outreach primary dental care and oral health care services to elderly people in residential care homes and Day Care Centres for the Elderly in April 2011. Given that dentists in the community had already taken up a nearly saturated service volume, any change to the Scheme might lead to an increase in the demand for private dental care services.

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34. In response to Ms Audrey EU's further enquiry about the yearly expenditure earmarked for the three-year pilot Scheme and the actual expenditures incurred in 2009 and 2010 respectively, SFH agreed to provide the requisite information after the meeting. SFH further advised that a total of 2 567 929 vouchers had been used as at end of February 2011, representing a reimbursement of about $128 million.

Eligible age for health care vouchers

35. Mr Fred LI asked about the reason why the Administration did not recommend lowering the eligible age for health care vouchers from 70 to 65 in the extended pilot period having regard to the fact that the eligible age for receiving Old Age Allowance was 65 or above.

36. Mr CHAN Hak-kan expressed disappointment at maintaining the eligible age for health care vouchers at 70 or above in the extended pilot period.

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37. SFH responded that there were different views on where to draw the line for the eligible age for receiving the health care vouchers. The Administration considered it prudent to continue the Scheme with the existing pool of eligible elderly and further test the effectiveness of the Scheme in the next three-year pilot period before recommending any changes to the Scheme.

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38. At the request of Mr Alan LEONG, SFH undertook to provide after the meeting information on the financial implication of lowering the eligible age to 60 or 65 and increasing the amount of vouchers for each elderly person to $1,000 in the next three-year pilot period.

Restrictions on the use of health care vouchers

39. Mr CHAN Hak-kan asked whether consideration could be given to removing the restriction on the use of the health care vouchers to pay for healthcare services provided by public GOPCs.

40. SFH replied in the negative. He pointed out that this would run contrary to the objective of the Scheme to enable elderly people to choose their own private primary care services in their local communities that suited their needs most, thus reducing their reliance on public healthcare services.

41. Mr Albert HO enquired about the reason for maintaining the restriction on the use of the vouchers for the purchase of drugs at pharmacies or other medical items.

42. SFH explained that it would be difficult for the Administration to ascertain whether the drug purchased was needed by the elderly concerned. The restriction was in line with the principle of prudent use of public money.

Privacy of patients

43. Ms Audrey EU was concerned that the Administration's proposal to capture information on the healthcare services provided to voucher users would not only pose an administrative burden on the enrolled healthcare service providers but also infringe upon privacy of patients.

44. SFH clarified that the enrolled service providers were only required to provide specific clinical diagnosis for each individual voucher user, and not details of the diagnosis-related group the user belonged to. In addition, information stored in the eHealth System, including the diagnosis information, could only be accessed by the patient and the service provider

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concerned. SFH stressed that protection of patient data privacy was of paramount importance in developing the Scheme. To this end, a Privacy Impact Assessment and a Privacy Compliance Assessment on the design and operational procedures of the Scheme had been conducted prior to implementation of the Scheme.

Way forward

45. Mr CHEUNG Kwok-che noted with concern that all unused vouchers would lapse on the expiry of the extended pilot period ending on 31 December 2014, which implied that the Administration might cease to continue the Scheme after the next three-year pilot period. He asked whether resources would then be channelled to expanding the service scope of the Elderly Health Centres to meet both the curative and preventive healthcare needs of all elderly people.

46. SFH pointed out that the provision of primary healthcare services by the public system alone was not the most cost-effective and sustainable way to deliver services to the elderly, taking into account a readily available pool of several thousand private healthcare professionals distributed across the territory providing a large number of choices for members of the public. To ensure the sustainability of the healthcare system, the Administration believed that it was worth to involve the private sector in the delivery of partially subsidized primary healthcare services, making better use of the resources available in the community to meet part of the service demand on the public sector. Through the implementation of the Scheme and other community-based healthcare pilot projects, the Administration sought to devise an effective model to enable elderly people to choose within their neighbourhood private primary healthcare services that best suited their needs. SFH stressed that he could not see the reason for not providing additional resources to continue the Scheme after the next three-year pilot period if the voucher model was proved to be effective in achieving its objectives. However, if the model was turned out to be ineffective, the resources would in future be channelled to other areas to enhance the health of the elderly.

47. Mr Alan LEONG enquired whether the interim review of the Scheme had assessed the feasibility of extending the "money follows patient" concept to other programmes.

48. SFH reiterated that the usage statistics and the interim review both revealed that the Scheme did not induce significant behavioural changes on the part of the elderly and the providers in seeking and providing primary healthcare services respectively. The recommendation to extend the

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Scheme on a pilot basis for another three years would allow the Administration to further test the "money follows patient" concept under the voucher model.

49. Concluding the discussions, the Chairman urged the Administration to take on board members' suggestions to further improve the Scheme.

VI. Promotion of organ donation and proposed "Garden of Life"

(LC Paper Nos. CB(2)973/10-11(08) and (09))

50. SFH briefed members on the progress of the Government's efforts in promoting organ donation in Hong Kong, including the proposal to establish a "Garden of Life" in the Kowloon Park to give public recognition to organ donation as a commendable life-saving act, details of which were set out in the Administration's paper (LC Paper No. CB(2)973/10-11(08)).

51. Mr CHAN Kin-por asked whether the Administration had conducted any study to find out the reasons why some people were not willing to donate their organs after death, as such information, if available, would help to shed light on how the promotion should be run to achieve greater effect. He further expressed concern about the Chinese name of the "Garden of Life" (i.e.「生命・源」) which might cause confusion to the public that it was referring to the end of life.

52. SFH responded that albeit the significant change of public attitude on organ donation in recent years, many people were hesitant to donate organs after death because they believed that dead bodies should be buried intact. That said, in cases where the deceased had made known their wish to donate organs, the family members would usually respect their wish.

53. As regards the Chinese name of the "Garden of Life", SFH said that it was created by local young artists to express the lives brought by the meritorious acts of organ donation. Instead of just naming the garden as "Organ Donation Garden", the subtle presentation would inspire people to give more thoughts about organ donation. Dr PAN Pey-chyou agreed that the name could carry the meaning of the cycles of life.

54. Dr PAN Pey-chyou noted with concern that the family consent rate for solid organ donation was about 50% in 2010, which remained steady over the years. Given the importance of family's acceptance, he considered it necessary to focus the promotional efforts on families to lessen reluctance and hesitation of family members regarding organ donation.

55. SFH responded that transplant coordinators in public hospitals would make the best effort to counsel relatives of potential donors and obtain their consent for organ donation. It should be pointed out that family members' decisions about donating their relatives' organs should be respected. The Administration would continue its promotional efforts to impress upon the public the importance of organ donation and to gradually inculcate a culture that was receptive and conducive to organ donation, as well as to encourage prospective donors to make known their wish to their families.

56. In response to Dr PAN Pey-chyou's further suggestion to rally the support of religious figures to promote the message of organ donation, SFH referred members to paragraph 7(a) of the Administration's paper and pointed out that DH had been collaborating with the Hospital Authority ("HA") and various community organizations including religious agencies to promote organ donation on different fronts.

57. Mr Albert HO suggested that the Administration should step up publicity and promotion among the younger generation to encourage them to become organ donors, as they were relatively more open-minded to the concept of organ donation. Consideration could also be given to organizing large-scale promotional activities on a regular basis.

58. SFH responded that efforts had been and would continue to be made by the Administration to instil in the younger generations that voluntary organ donation was a commendable act of charity and the norm rather than the exception. He pointed out that the number of young donors was relatively not significant in Hong Kong due to the sound healthcare system and the low local traffic and industrial accident rates.

59. Ms Audrey EU suggested that the Administration could organize a promotional campaign to solicit the support from the Legislative Council Members and their family members to promote the message of organ donation and the importance of family's consent to the community. SFH agreed to consider Ms EU's suggestion.

60. Mr Albert CHAN suggested that consideration could be given to requesting people to indicate their wish to donate organs after death when they applied for a driving licence or registered for the Hong Kong Identity Card. SFH responded that DH had been encouraging people to register at the Centralised Organ Donation Register their wish to donate organs after death through various channels.

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61. Mr Albert CHAN further said that to ensure that the wish of prospective donors would be followed, transplant coordinators of HA should not be required to seek consent from family members about donating their relatives' organs if their relatives had registered their wish to donate organs after death.

62. SFH responded that the healthcare professionals would find it difficult not to respect the decision of family members when the latter were suffering from the loss of their loved ones. Given the importance of family's acceptance, it was important for prospective donors to make known their wish to donate organs whilst they were alive so that their wish could be realized.

63. Mr CHAN Kin-por noted from the Annex to the Administration's paper that as at end of December 2010, 1 621 patients were waiting for kidney transplant. However, the wait for a donated kidney could be years long as the number of kidneys donated for transplant was less than 100 per year. He asked about the measures to be put in place to address the pressing demand for kidney transplant.

64. SFH explained that for kidney transplantation, apart from waiting for a deceased donor kidney, patients could also receive a kidney from a living donor. Given that patients with renal disease could receive haemodialysis treatment when waiting for kidney transplantation, there were relatively fewer living kidney donations when compared to other life-threatening diseases. SFH further said that in 2011-2012, the Administration would increase the resource allocation to HA for enhancing the haemodialysis service for patients with end-stage renal disease by providing additional hospital and home haemodialysis places.

VII. Initiatives for enhancement of mental health services in the Hospital Authority

(LC Paper Nos. CB(2)1220/10-11(06), (07) and RP04/10-11)

65. Head (Research) briefed members on a comparison of the key features of the mental healthcare system and relevant services in England, Australia, Singapore and Hong Kong, details of which were set out in the Research Report entitled "Mental health services in selected places" ("the Research Report") (RP04/10-11).

66. SFH then briefed members on the initiatives to be introduced by HA in 2011-2012 to enhance the support for persons with mental health problems as well as the follow-up action on a review with reference to an

incident involving a mental patient in Kwai Shing East Estate in May 2010, details of which were set out in the Administration's paper (LC Paper No. CB(2)1220/10-11(06)).

67. The Chairman informed members of his decision to extend the meeting for 15 minutes beyond its appointed time to allow more time for discussion.

68. Mr CHAN Kin-por asked the Administration whether it would assess the degree of risk of persons who had attempted suicide to commit suicide again, as studies showed that the risk of these people to attempt suicide was more than 10 times of that of other people. He also sought explanation on the difference in the median waiting time for first appointment of routine cases at psychiatric specialist out-patient clinics ("SOPCs") among clusters.

69. Chief Manager (Integrated Care Programs), HA advised that doctors of HA would use standardized risk assessment tools to assess whether a patient was at a high risk of committing suicide. SFH added that according to a study conducted by the University of Hong Kong on suicide prevention strategies, an effective approach to prevent suicide in community settings was to reduce people's access to suicide means. For instance, it was found that there was a drop in the number of suicidal deaths due to carbon monoxide poisoning by burning charcoal after making it less convenient for people to buy charcoal in the community.

70. Director (Cluster Services), HA explained that the average waiting time at psychiatric SOPCs varied among different clusters due to the difference in service demand. As a result of the introduction of various initiatives to shorten the waiting time at psychiatric SOPCs, the median waiting time for first appointment of non-urgent cases at psychiatric SOPCs had been reduced from 27 weeks in 2006-2007 to around nine weeks in 2010-2011. The upper quartile (75% percentile) waiting time for these cases had also been reduced from 49 weeks in 2006-2007 to 23 weeks in 2010-2011.

71. In response to Mr CHAN Kin-por's further enquiry on whether cross-cluster utilization of psychiatric SOPC services was allowed, Director (Cluster Services), HA replied in the positive, and pointed out that many patients still sought consultation at the psychiatric SOPCs in the Kowloon West and the New Territories West clusters instead of those in their own residential districts given that the two major psychiatric hospitals (i.e. Kwai Chung Hospital and Castle Peak Hospital) were located in these clusters.

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72. Noting from the Research Report that Hong Kong had lagged far behind other places in terms of ratio of psychiatric workforce per 10 000 population, Dr PAN Pey-chyou asked whether there would be an increase in manpower of HA for mental health services.

73. SFH said that the Working Group on Mental Health Services, which was chaired by himself, had affirmed the trend of shifting the focus of treatment of mental illness from in-patient care to community and ambulatory services so as to enhance patients' prospect of re-integration into the community after rehabilitation. More resources had therefore been allocated by the Administration in recent years to enhance the support services for mental patients in community settings. The initiatives to be introduced by HA in 2011-2012 also aimed at strengthening the support services in this regard. It was hoped that in the future, primary healthcare service providers could also be further engaged to facilitate early detection and early intervention of mental health problems.

74. Mr CHEUNG kwok-che considered that psychiatric social workers performed an indispensible role in supporting mental patients in community settings. He asked whether the Food and Health Bureau had engaged the Labour and Welfare Bureau ("LWB") in devising the various initiatives to further enhance the support to different groups of mental patients, and if so, the resources to be allocated to the Social Welfare Department ("SWD") for the implementation of these initiatives.

75. SFH pointed out that the Working Group on Mental Health Services, which was responsible for assisting the Government in reviewing the mental health services on an ongoing basis, comprised representatives of LWB, HA and SWD, as well as academics and relevant professionals and service providers from both the healthcare and social welfare sectors.

76. Commissioner for Rehabilitation advised that in 2011-2012, the Government would allocate about $40 million to strengthen the manpower of the Integrated Community Centres for Mental Wellness, and to dovetail with HA's Case Management Programme to provide intensive, continuous and personalized support for patients with severe mental illness living in the community. The Government would also allocate an additional full year funding of about $16 million to provide 31 additional psychiatric medical social workers to enhance the psychiatric medical social services to dovetail with HA's new initiatives for ex-mentally ill patients as well as services for autistic children and their families.

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77. Mr CHEUNG Kwok-che urged the Administration to step up public education to promote mental health and to draw up a long-term development plan for mental health services in the next five or 10 years.

78. Whilst expressing support for the service direction to shift the focus of treatment of mental illness from in-patient care to community and ambulatory services, Mr Albert HO urged the Administration to expedite its feasibility study regarding the introduction of statutory community treatment orders for mental patients and review the Mental Health Ordinance (Cap. 136) to empower medical superintendents to detain patients in hospital if the mental conditions of the patients concerned made it appropriate for them to receive treatment in hospital. Mr HO further urged the Administration to address the problem of short consultation time for patients at psychiatric SOPCs and increase the use of new psychiatric drugs with less disabling side effects.

79. Director (Cluster Services), HA responded that whilst there was room for improvement in the consultation time at the psychiatric SOPCs, efforts had been and would continue to be made by HA to strengthen the support to its patients through a multi-disciplinary team approach which involved not only the psychiatrists but also other professionals such as occupational therapists and psychiatric nurses. The case managers under the Case Management Programme would also provide periodic reports on the conditions of their patients to the psychiatrists. This would help to shorten the time required by the psychiatrist concerned to understand the conditions of the patient during follow-up consultation.

80. On the use of new psychiatric drugs, Director (Cluster Services), HA advised that the Government had provided HA with additional recurrent allocation in recent years to provide new psychiatric drugs. In 2011-2012, an additional recurrent expenditure of about $40 million would be provided to HA for further expanding the provision of new drugs with proven efficacy. Apart from introducing new psychiatric drugs in its drug formulary for provision to patients at standard charges, HA had also revised the prescription guidelines to enable more mental patients to be treated with new psychiatric drugs. Director (Cluster Services), HA further said that at present, expenditure for new drugs had accounted for more than 85% of the expenditure of HA on psychiatric drugs and more than 70% of patients with severe mental illness were already being prescribed with new psychiatric drugs

81. Mr Albert CHAN held the view that the development of mental health services in Hong Kong had lagged far behind other places. This was evidenced by the facts that the number of mental patients in Hong

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Kong was five times of that of Singapore and the public expenditure on mental health services only accounted for 0.2% of the Gross Domestic Product of Hong Kong, which was about three times less than that of the United Kingdom. He considered that Administration's faulty policies had exerted tremendous pressure on members of the general public and led to a rise in the number of people with mental health problem.

82. Ms LI Fung-ying enquired about the measures to be put in place to enhance early identification and intervention of mental problems.

83. SFH responded that the Administration attached great importance to the early detection of mental health problems in the primary care setting. In view of the success of its Early Assessment and Detection of Young Persons with Psychosis Programme in early identification of persons with psychotic disorders and the provision of prompt treatment to prevent deterioration and unnecessary hospitalization, HA would expand the service target of the Programme to include adults in 2011-2012.

84. Chief Manager (Integrated Care Programs), HA supplemented that HA would expand the Integrated Mental Health Programme to cover all clusters to enhance the assessment and consultation services for patients with common mental disorders who sought consultation at GOPCs. Under the Programme, patients with chronic conditions would be assessed for early signs of mental health problems and provided with early treatment in the primary care settings by family medicine specialists and general practitioners working in multi-disciplinary teams.

85. Mr CHEUNG Kwok-che suggested that a joint meeting with the Panel on Welfare Services should be held to further discuss the subject and receive views from deputations. The Chairman said that he would follow up the matter with the Clerk.

86. There being no other business, the meeting ended at 10:47 am.

Council Business Division 2
Legislative Council Secretariat
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