立法會
Legislative Council

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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 2010-2011 Legislative Council ("LegCo") session. It will be tabled at the Council meeting of 13 July 2011 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, 11 July 2007 and 2 July 2008 for the purpose of monitoring and examining Government policies and issues of public concern relating to health services matters. The terms of reference of the Panel are in **Appendix I**.

3. The Panel comprises 17 members, with Dr Hon LEUNG Ka-lau 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

Obstetric services in Hong Kong

4. The subject of obstetric services in Hong Kong was high on the agenda of the Panel. Noting an increasing demand for public obstetric services from both local and non-local women, the Panel was gravely

concerned about the capacity of the Hospital Authority ("HA") to cope with the demand. In particular, members were worried about the high turnover rates of medical staff and nursing staff of the obstetric and gynacecology specialty in public hospitals, which stood at 9.3% and 7.0% in 2010-2011 respectively, as well as the increasing bed occupancy rate of the neonatal intensive care unit of public hospitals, which surged from an average of 94% in 2010 to about 108% in February 2011. Members urged the Administration to ensure an adequate provision of obstetric services for local pregnant women. There was also a suggestion that children who were born in Hong Kong but whose parents were non-local residents should be charged at the cost recovery level for the use of public neonatal intensive care services.

5. The Administration assured members that priority would be accorded to local pregnant women to use obstetric services. HA would only accept booking from non-local pregnant women when spare service capacity was available. To this end, HA had decided that the booking for delivery in public hospitals would be closed from 8 April 2011 for non-local pregnant women if their expected delivery dates fell within April to end of December 2011 to ensure the adequate provision of obstetric services for local expectant mothers.

6. While agreeing that sufficient places in public hospitals should be reserved for delivery by local women, members took the view that non-local women whose spouses were permanent Hong Kong residents should not be treated on an equal footing with those non-local women with no marital ties in Hong Kong. The Panel passed a motion at its meeting on 11 April 2011 urging the Government to, apart from reserving adequate obstetric services quota for local pregnant women, give priority to women whose spouses were permanent Hong Kong residents in allocating the remaining quota.

7. Members continued to follow up on the progress on the provision of obstetric services in Tseung Kwan O Hospital in 2013-2014. In view of the high turnover rates of doctors and nurses of obstetric and paediatric staff of HA, the Administration proposed that the commissioning of the obstetric and neonatal intensive care services in Tseung Kwan O Hospital would be in phases and the appropriate timing for the commissioning of such services would be reviewed in 2012-2013. While noting that the high wastage and turnover of the doctors and nurses of the obstetric and paediatric specialties in public hospitals had put the obstetric and paediatric services under extreme pressure, many members were disappointed at the Administration's proposal. They urged the Administration to implement effective measures

to enhance recruitment and retention of staff, such as relaxing the restrictions on overseas medical doctors practising in Hong Kong as well as improving the working environment of staff, in order to meet the increasing service demand from local pregnant women, particularly from the young couples in the Tseung Kwan O district.

Wastage of doctors in HA

8. Members discussed the initiatives introduced by HA to attract and retain doctors. These included a new career structure with higher starting and maximum pay for Residents and Associate Consultants, enhanced promotion prospects and training opportunities as well as improvement of working conditions. Some members considered that the initiatives could hardly address the problems of excessive call frequency and work hours of doctors. They suggested that a cap should be imposed on the weekly work hours for doctors and more part-time private practitioners should be recruited to help out in the pressurized outpatient clinics. Members also considered it important for the Administration to conduct manpower planning for doctors in each clinical specialty based on a fixed doctor-bed ratio or doctor-outpatient attendee ratio in order to better address the problem of shortfall of doctors.

9. Pointing out a high variation in the median waiting time for specialist outpatient appointment among different hospital clusters, many members took the view that such high cross-cluster variation was caused by an uneven distribution of resources among public hospitals. They requested the Administration to conduct a comprehensive review of the resource allocation mechanism among different hospital clusters. HA agreed that it would take into account, among others, the workload of hospitals when allocating its resources to the hospital clusters in July each year. In the coming year, HA would adopt a bottom-up approach to solicit views from the specialty committees and frontline doctors on pressurized areas that required additional resources, so as to improve the fairness and transparency of resource allocation within HA.

Wastage of nurses in HA

10. Members was gravely concerned about the high turnover rate of nurses in public hospitals, in particular the Enrolled Nurses/Midwives/other nurses in the Obstetric and Gynaecology specialty of HA, which had surged from 12.4% in 2006-2007 to 73.5% in 2010-2011. In their view, such high turnover rate had clearly demonstrated the ineffectiveness of the past

measures implemented to attract and retain the nursing staff. Holding the view that monetary return might not be the primary reason for the departure of nurses from the public sector, members urged HA to conduct an in-depth study on the reasons for the high wastage of its nursing staff.

11. Some members considered that the root of the problem of the high wastage of nurses was the lack of a nurse-to-patient ratio for projecting the nursing manpower requirement of HA. They suggested that the Administration should formulate a blueprint for the long-term healthcare planning and work out a nurse-to-patient ratio in order to estimate the manpower requirement for nurses in the public sector. Members considered that such information was necessary for the Administration to determine the number of training places required and on the need to employ overseas graduates.

12. Noting the expansion of the obstetric services in the private healthcare sector for meeting the growing demand by Mainland women, members were concerned whether the total number of nurses available for appointments in the coming three years (i.e. 2012-2013 to 2014-2015) could meet the demand of nurses from the public and private healthcare sectors, as well as the social welfare sector. Some members suggested that the Administration should consider providing assistance to nurses trained and practised outside Hong Kong in applying for practise in Hong Kong or secure care-related employment in public hospitals.

13. The Administration affirmed that it would assess the manpower requirement for various healthcare professionals and the assessment would take into account views of the healthcare and the social welfare sectors. HA had also implemented a basket of measures to address the problem of nursing manpower shortage such as employing some 400 part-time nurses to help out in the pressurized areas and providing better incentive for nurses to work beyond their conditioned hours. As regards assisting nurses trained and practised outside Hong Kong to practise in public hospitals, the Administration explained that it was a requirement of the Nursing Council of Hong Kong that an applicant trained outside Hong Kong had to possess a valid certificate issued by a certifying body recognized by the Nursing Council as evidence of competency to practise nursing in Hong Kong. The Administration assured members that both the public and private sectors had offered a number of employment opportunities for care-related support workers.

Drug Formulary of HA

14. The Panel continued to follow up the subject of Drug Formulary of HA. The Drug Formulary was introduced in 2005 with a view to ensuring equitable access by patients to cost-effective drugs of proven safety and efficacy by standardizing the drug policy and drug utilization in HA. The Formulary was developed with evaluation of new drugs and review of the prevailing list of drugs by relevant experts on a regular basis. The review was based on the scientific and clinical evidence on the safety, efficacy and cost-effectiveness of drugs, having regard to the views of patient groups.

15. Members expressed grave concern on the decisions in relation to the introduction of new drugs and review of existing drugs in the Drug Formulary. They criticized HA for its low transparency in providing explanations and supporting evidence to the public as well as frontline doctors in relation to its decisions on the Drug Formulary. They urged HA to enhance transparency on its regular review of the Formulary, including making public the composition of the expert committees, meeting papers of the expert committees in evaluating new drugs and reviewing the prevailing list of drugs, a summary of the decisions of the expert committees and the reasons for the decisions.

16. HA acceded to members' request to introduce a number of measures to enhance the transparency of the Formulary and to improve the accessibility of information and communications with relevant stakeholders of the Formulary. The measures included uploading regularly to the website of HA the list of new drugs to be reviewed, decisions of the expert committees on individual applications, together with a list of references that had been taken into account in consideration of the applications. As regards the composition of the expert committees, HA would make public the professional composition of the expert committees and the various expert panels for the individual specialties. However, HA would not disclose the names of individual members serving on the expert committees and the relevant expert panels as it might impose unwarranted pressure on committee members and to ensure the impartiality of expert opinions in the discussion process.

17. Many members expressed grave concern on the financial burden on patients who needed to purchase costly self-financed drugs which were not on the subsidy list of the Samaritan Fund but were proven to be of benefit to them. Members called on the Administration to strengthen the safety net to benefit patients including those from the middle class who needed costly

self-financed drugs for treatment. Many members held the view that drugs which were proven to be of significant benefits should be covered by the standard fees and charges in public hospitals and clinics, rather than being classified as self-financed drugs with safety net. Some members suggested putting a cap on the expenses borne by each patient for purchasing those costly self-financed drugs or making a patient's expenditure on those drugs tax deductible.

18. In the Administration's view, the principle was to ensure effective use of public resources and maximize health benefits to more patients. Drugs which were proven to be of significant benefits but too expensive for HA to provide as part of its standard services could be provided through the safety net of the Samaritan Fund. To meet the rising demand for assistance, the Government had injected $1 billion to the Samaritan Fund in 2008-2009.

Healthcare Reform Second Stage Public Consultation – Health Protection Scheme

19. The Panel examined the proposal of the voluntary Health Protection Scheme ("the Scheme") under the Healthcare Reform Second Stage Public Consultation. The proposed Scheme aimed to make available government-regulated health insurance to provide better choices to those who chose private healthcare services. It also aimed to ease the pressure on the public healthcare system by encouraging more people to use private healthcare on a sustainable basis, and enhance the sustainability of the entire healthcare system. The Financial Secretary also pledged to draw $50 billion from the fiscal reserves to take forward the healthcare reform.

20. One of the key features of the Scheme was the guaranteed acceptance of all applicants including the high-risk groups such as the elderly and those with pre-existing medical conditions. While considering this feature an improvement, members were concerned about the financial viability of the high-risk groups for joining the Scheme. If the Scheme could not attract a substantial number of subscribers, it might lack the critical mass to be financially sustainable. Members suggested that consideration be given to offering a tax deduction for the premiums in order to provide incentive for individuals to subscribe to the Scheme.

21. Noting the call from many deputations for extending the benefit coverage of the Scheme to out-patient services, some members suggested that in addition to out-patient services, the benefit coverage of the Scheme should also be extended to cover the first specialist consultation in general as

well as physiotherapy that entailed high cost.

22. In the Administration's view, such extension would create the problem of moral hazard or might lead to premium escalation. As insurers participating in the Scheme could offer top-up components to cover such services and the public healthcare system would provide a safety net of last resort for patients in need, the Administration maintained its view on the proposed benefit coverage to medical conditions requiring hospital admission or ambulatory procedures.

23. Members expressed diverse views on the use of the $50 billion fiscal reserve. Some members welcomed the proposal to make use of the $50 billion fiscal reserve to provide financial incentives to attract people to subscribe to the Scheme while others members considered that the $50 billion should be used to improve public healthcare services. Some members were of the view that a public entity should be set up to offer health insurance plans under the Scheme to ensure compliance with the Scheme requirements and set the benchmarks for health insurance plans under the Scheme.

Commencement of provisions relating to proprietary Chinese medicines in the Chinese Medicine Ordinance

24. The provisions in the Chinese Medicine Ordinance related to the mandatory registration of proprietary Chinese medicines commenced operation on 3 December 2010. Noting that many deputations had faced great difficulties, in terms of technical and financial viability, in meeting the requirements for the registration of proprietary Chinese medicines, members were disappointed at the lack of support provided by the Government to the trade in meeting the registration requirements. There was a suggestion that financial assistance, such as the setting up of a loan scheme, should be provided to assist the trade in meeting the high testing costs in order to comply with the legislative requirements for the registration of proprietary Chinese medicines.

25. Members also expressed grave concern about the lack of transparency and objectivity of the assessment criteria and procedure for the registration of proprietary Chinese medicines. They considered it high time to conduct a review on the policy regulating Chinese medicines. To enable more focused discussion, the Panel agreed at its meeting on 14 March 2011 to appoint a subcommittee to study the registration of Chinese medicines.

26. The approval of the House Committee was obtained at its meeting on 8 April 2011 for the activation of the Subcommittee on Registration of Proprietary Chinese Medicines in June 2011. The Subcommittee has just started its work and has scheduled a series of meetings to examine the subject in detail.

Mental health services

27. In the course of discussion on the initiatives to be introduced by HA in 2011-2012 to enhance the support for persons with mental health problems, members expressed grave concern on the different median waiting time for first appointment of routine cases at psychiatric specialist out-patient clinics among different hospital clusters, as well as the short consultation time for patients at the psychiatric specialist out-patient clinics. They urged the Administration to increase the manpower of HA for mental health services.

28. The Administration explained that the focus of treatment of mental illness had been shifted from in-patient care to community and ambulatory services so as to enhance patient's prospects of re-integration into the community after rehabilitation. Resources had therefore been allocated to enhance the support services for mental patients in community settings.

29. While expressing support for the service direction to shift from in-patient care to community and ambulatory services, some members called on the Administration to allocate sufficient resources to the social welfare sector to enhance the support to mental patients in community settings. The Administration was also requested 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 were so warranted. Members also urged the Administration to draw up a long-term development plan for mental health services.

Primary care development strategy – Primary care campaign

30. The Administration briefed members on the territory-wide Primary Care Campaign as part of the Government's primary care development strategy. Members were informed that the Campaign would first focus on promoting the primary care services provided by family doctors and dentists through the Primary Care Directory. Greater involvement in the Campaign of other healthcare professionals as part of the primary care team would be

made in a progressive manner.

31. While welcoming the promotion of the family doctor concept to members of the public, members cast doubt on the effectiveness of the Primary Care Directory in promoting the concept of family doctor and preventive care. Given the enrolment in the Directory on a voluntary basis, members were concerned whether there would be adequate family doctors enrolled in the Directory. Members also expressed concern on the timetable for the inclusion of the information of other healthcare professionals such as Chinese medicine practitioners in the Directory.

32. The Administration explained to members its phased approach in the development of the Directory. The first phase would cover doctors and dentists, while the next step would cover Chinese medicine practitioners to be followed by nurses and other allied health professionals. In the Administration's view, the Directory could assist members of the public to choose primary care providers who could serve them as family doctors. The proportion of the population having a family doctor for the provision of continuing and co-ordinated care was expected to increase from the current 20% to 30% with the promotion of the family doctor concept.

33. Members did not fully accept the Administration's explanation. They called for greater effort from the Administration to engage family doctors to enhance communication with their patients, fostering the development of a close partnership between family doctors and patients and in turn changing the existing habit of doctor-shopping.

Prevention and control of influenza

34. Noting that influenza activity in the winter season of 2010 appeared higher than the average, members were concerned about the effectiveness of the protection conferred by the seasonal influenza vaccine. In particular, members were concerned that influenza-like illness outbreaks still occurred at institutions, albeit that the elderly people living in institutions had received vaccination under the Government Vaccination Programme. The Administration explained that the immune response to the vaccine varied among people and the persistent cold weather in 2010 had contributed to the spread of influenza virus. The Administration affirmed that the currently available seasonal vaccines conferred good protection against influenza.

35. Given the low take-up rate of the seasonal influenza vaccine for the target groups under the various government vaccination programmes,

members urged the Administration to consider extending the vaccination programmes to people outside the target groups, such as primary school students to prevent outbreaks in schools, as well as young people aged 19 years or below who recorded a high infection rate. This would also prevent the vaccines from going to waste as in the case of Human Swine Influenza vaccines purchased by the Government last year. The Administration maintained its view that seasonal influenza vaccination was recommended for individual protection rather than prevention and control of cross infection of the disease in a particular setting. The seasonal influenza vaccination target groups were determined each year based on a range of scientific considerations. At this stage, there was not enough scientific evidence recommending the extension of coverage of the vaccination programmes to other groups of people.

36. Holding the view that HA should be well prepared for the surge in hospital admission during the influenza peak season, members were concerned whether there would be sufficient manpower and hospital beds to accommodate the increase in admission. It was suggested that community nurses should be deployed to pressurized wards to meet the rise in hospital admission. The Administration reassured members that public hospitals would, as appropriate, transfer patients to less busy wards and postpone some non-urgent procedures and surgeries to cope with the demand in hospital admission. Since community nurses played a vital role in the prevention of influenza through the provision of nursing support to elderly patients in the community setting, the Administration considered it not appropriate to deploy community nurses in this regard. Contingent measures such as medical staff providing overtime and/or voluntary work would be implemented to handle the surge in demand.

<u>Pilot project on outreach primary dental care services for elderly in residential care homes and day care centres</u>

37. Members supported the proposal for engaging qualified and capable Non-Governmental Organizations ("NGOs") to provide subsidized outreach primary dental care and oral health care services to needy elderly in residential care homes or Day Care Centres for the Elderly. Members suggested that further improvement could be made by providing subsidy to elderly people who were neither institutionalized elderly nor Comprehensive Social Security Assistance ("CSSA") recipients who were unable to afford the dental expenses. In members' view, all elderly people should be eligible for free primary dental care services in the long run.

38. At members' request, the Administration agreed to consider extending the pilot project to other groups of elderly by phases having regard to the experience from the pilot project, such as whether access to primary dental care could lead to an improvement in the health and quality of life of the elderly, as well as the availability of financial and manpower resources. The Administration would conduct an interim review of the pilot project to decide how to take forward the pilot project.

39. While welcoming an increase in resources for improving the oral health of the elderly, some members took the view that there was a mismatch of resources in meeting the need of the elderly. They pointed out that the most common oral health problem facing the elderly was tooth loss but the services to be provided in the pilot project did not include tooth replacement. Noting that some 200 000 elderly people were edentulous or only had retained roots, members urged the Administration to consider providing each of these elderly people by batches in a four-year period a subsidy of $10,000 for them to replace five or six missing teeth.

40. The Administration maintained its position that priority should be given to improving oral health of and dental care for needy elderly living in residential care homes or Day Care Centres for the Elderly. If dental treatments were required by these elderly people, the selected NGOs would be required to arrange for the elderly the necessary follow-up curative treatments. For elderly people on CSSA, the cost of treatment would be covered by the dental grant. For non-CSSA recipients, NGOs would consider providing or arrange to provide financial assistance to those in financial difficulties to pay for the treatment.

Elderly Health Care Voucher Pilot Scheme

41. The Administration briefed members on the proposal to extend the Elderly Health Care Voucher Pilot Scheme for another three years (from 1 January 2012 to 31 December 2014), with an increase in the amount of health care vouchers per year from $250 to $500 and other improvements to the operational aspects of the Scheme.

42. While not objecting to the extension of the Pilot Scheme for another three years, members considered that the increase of voucher value from $250 to $500 per year was not sufficient to meet the medical needs of the elderly people. Members also expressed concern about the low enrolment rate of medical practitioners in the Pilot Scheme. They urged the Administration to step up efforts in encouraging those healthcare services

providers who practised in the New Territories or public housing estates to enrol in the Pilot Scheme. Many members also expressed disappointment at maintaining the eligible age for health care vouchers at 70 or above in the extended period. They called for the lowering of the eligible age for health care vouchers to 60 or 65. They also asked the Administration to consider providing additional subsidy as an incentive for the elderly to seek dental or health check-up services. Members also expressed concern 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 the privacy of patients.

43. The Administration explained that the Pilot Scheme aimed at encouraging the elderly to seek private primary healthcare services in their neighbourhood through the provision of partial subsidy. Having regard to the need to ensure the prudent and effective use of public money, the Administration needed to carefully consider whether the increase in voucher amount would affect the healthcare seeking behaviour among elderly people, the prices to be charged by healthcare service providers, and the amount the elderly were willing to co-pay. The proposed extension of the Pilot Scheme was to allow fuller assessment of the effectiveness of the Scheme and the utilization of health care vouchers. The Administration maintained its view that it would not recommend making any changes to the rules of the Pilot Scheme at this stage such as lowering the age eligibility. Subject to a review of the effectiveness of the Pilot Scheme in the next three-year period, consideration might be given to revisiting whether some of these rules should be changed.

Proposed regulatory framework of medical devices

44. The Panel discussed the proposed regulatory framework of medical devices. Members expressed concern on the definition and classification of medical devices. Citing corrective and non-corrective lens as an example, members queried the reason for adopting a different approach to regulate these corrective and non-corrective contact lens which were subject to statutory control and regulatory control through listing in a Schedule to the proposed legislation respectively, albeit that both were intended for use on human body and would potentially have similar adverse effect on human body.

45. The Administration explained that for the purpose of the proposed legislation, the definition of medical device would be based largely on the

recommendation of the Global Harmonization Task Force. Despite the attempt to provide a clear definition for medical device, a number of products appeared to be "borderline" cases. It was therefore proposed to empower the Director of Health to designate through a form of Schedule those products which were to be included for regulatory control.

46. Members did not accept the Administration's explanation. They pointed out that such an approach would cause confusion to the public and place unnecessary burden on the trade and industry. They sought information on the factors which the Director of Health would take into account in determining the products which should be subject to regulatory control. It was suggested that an independent committee should be set up to advise the Director in this regard.

47. Members also expressed grave concern on the pre-market control of medical devices. They considered it important for the regulatory authority to determine whether a medical device was safe and performed as intended before market entry. Members urged the Administration to ensure that the Department of Health would have adequate manpower and resources to effectively perform the assessment work.

48. Members noted that the proposed legislation would allow personnel who were not statutorily registered healthcare professionals to operate the intense pulsed light equipment, provided that they had undergone training and passed the pulsed light trade test run by reputable institutions. Members considered that the Panel should invite views from the trade in this regard.

49. As the Administration had taken seven years to work out the proposed regulatory framework since it first unveiled its plan to regulate medical devices in 2003, members expressed dissatisfaction at the slow progress in putting in place regulatory control on medical devices. The Administration explained that to prepare for the establishment of the a statutory regulatory framework, a Regulatory Impact Assessment was conducted in 2007 to 2008 to examine the implications of the possible options for the proposed statutory regulation of medical devices. The Administration then briefed the Business Facilitation Advisory Committee on the proposed legislative framework in March 2010. While expressing general support for the proposed legislative framework, the Committee strongly recommended the Administration to conduct a Business Impact Assessment to fully assess the implications of the regulation for the trade.

50. The Panel requested the Administration to report on the outcome of the Business Impact Assessment together with the details of the legislative proposal in 2011.

Redevelopment of Yan Chai Hospital

51. Members discussed the proposal to redevelop Blocks C, D, E and F of Yan Chai Hospital into a community health and wellness centre. They expressed concern on the capability of the new community health and wellness centre to address the service needs of the elderly in view of the ageing population of the district. The Administration assured members that the proposed community health and wellness centre would be able to promote healthy ageing and address the changing service needs. The new community health and wellness centre would have a Primary Care Centre to provide primary healthcare services for individuals at different stages of life including the elderly. It would also have a Specialist Care Centre to provide, among others, assessment and stabilization services in an ambulatory setting for patients suffering from chronic diseases such as diabetes, hypertension and chronic obstructive airway disease which were common chronic diseases afflicting the elderly. The Administration considered that the centre would be able to deliver comprehensive and integrated healthcare services for the elderly.

52. Some members remained of the view that primary healthcare was insufficient on its own to address the needs of the elderly and there was a need to enhance the specialist support in the provision of care for the elderly. Other members considered that services other than those proposed by the Administration should also be provided at the redeveloped Yan Chai Hospital to meet the service needs of the district. They urged the Administration to consider providing obstetric services and ambulatory care facilities, such as psychiatric day hospital, in the redeveloped Yan Chai Hospital. There was also a strong request for resuming the provision of urology service at the redeveloped Yan Chai Hospital.

Organ donation

53. The Panel continued to follow up on the progress of the Government's efforts in promoting organ donation in Hong Kong. Members noted with concern that the family consent rate for solid organ donation was about 50% in 2010. Given the importance of family's acceptance, members considered it necessary to focus the promotional efforts on families to lessen reluctance and hesitation of family members regarding organ donation. There was a

suggestion that the Administration should organize a promotional campaign to solicit 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.

54. Members also put forward a number of other suggestions to promote the message of organ donation. These included rallying the support of religious figures; stepping up publicity and promotion among the younger generation; and 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. The Administration agreed to consider members' suggestions and affirmed that the Department of Health would continue to encourage people to register at the Centralized Organ Donation Register their wish to donate organs after death through various channels.

Other issues discussed

55. Other issues discussed by the Panel included Government's proposal to install and implement an electronic system to conduct online checking of the eligibility of non-permanent Hong Kong Identity Card holders for subsidized public healthcare services, creation of new directorate posts in the Department of Health, redevelopment of Phase Two of Caritas Medical Centre, Fu Shan Public Mortuary Incident and hospital accreditation in public hospitals.

Meetings held

56. During the period between October 2010 and end of June 2011, the Panel held a total of 15 meetings. Another two meetings have been scheduled for July 2011.

Council Business Division 2
Legislative Council Secretariat
4 July 2011

Appendix I

Legislative Council

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 2010 - 2011 session

Chairman	Dr Hon LEUNG Ka-lau
Deputy Chairman	Dr Hon Joseph LEE Kok-long, SBS, JP
Members	Hon Albert HO Chun-yan Ir Dr Hon Raymond HO Chung-tai, SBS, S.B.St.J., JP 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 Cyd HO Sau-lan Hon CHAN Hak-kan Hon CHAN Kin-por, JP Hon CHEUNG Kwok-che Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou Hon Alan LEONG Kah-kit, SC Hon Albert CHAN Wai-yip (Total : 17 Members)
Clerk	Ms Elyssa WONG
Legal adviser	Miss Evelyn LEE
Date	13 April 2011