立法會
Legislative Council

LC Paper No. CB(2)711/11-12
Ref : CB2/PL/HS (These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 14 November 2011, at 8:30 am
in Conference Room 1 of the Legislative Council Complex

Members present	:	Dr Hon LEUNG Ka-lau (Chairman) Dr Hon Joseph LEE Kok-long, SBS, JP (Deputy 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 Vincent FANG Kang, SBS, JP Hon CHEUNG Hok-ming, GBS, JP Hon WONG Ting-kwong, BBS, JP Prof Hon Patrick LAU Sau-shing, SBS, JP Hon Cyd HO Sau-lan Hon CHAN Hak-kan Hon CHAN Kin-por, JP Hon CHEUNG Kwok-che Dr Hon PAN Pey-chyou Dr Hon Samson TAM Wai-ho, JP
Members absent	:	Hon IP Kwok-him, GBS, JP Hon Alan LEONG Kah-kit, SC
Public Officers attending	:	Item IV Dr York CHOW Yat-ngok, GBS, JP Secretary for Food and Health Mr Thomas CHAN, JP Deputy Secretary for Food and Health (Health) 2

		Dr Jenny LAM Associate Consultant (Research Office)
		Dr Richard A Collins Scientific Review Director (Research Office)
		Item V
		Dr Gloria TAM, JP Deputy Director of Health
		Mr Chris SUN Deputy Secretary for Food and Health (Health) Special Duties
		Dr Tina MOK Principal Medical & Health Officer (1) Department of Health
		Item VI
		Dr W L CHEUNG Director (Cluster Services) Hospital Authority
		Ms Anna LEE Chief Pharmacist Hospital Authority
		Ms Angela LEE Principle Assistant Secretary for Food and Health (Health) 2
Clerk in attendance	**:**	Ms Elyssa WONG Chief Council Secretary (2) 5
Staff in attendance	**:**	Ms Alice LEUNG Senior Council Secretary (2) 2
		Ms Maisie LAM Senior Council Secretary (2) 5
		Ms Priscilla LAU Council Secretary (2) 5

Ms Sandy HAU
Legislative Assistant (2) 5

Miss Liza LAM
Clerical Assistant (2) 5

Action

I. Confirmation of minutes
(LC Paper No. CB(2)147/11-12)

The minutes of the meeting held on 13 October 2011 were confirmed.

II. Information paper(s) issued since the last meeting
(LC Paper Nos. CB(2)154/11-12(01) and (02))

2. Members noted the letter dated 14 July 2011 from the Chairman of Hong Kong Government Pharmaceutical Dispenser Association to the Secretary for Civil Service expressing views on dispensaries of the General Outpatient Clinics of the Hospital Authority ("HA") manned by dispensers in the capacity of "approved persons" and the Administration's reply dated 12 October 2011 to the Association which were issued since the last meeting.

3. While pointing out that the subject straddled the policy areas of public service and health services, Dr PAN Pey-chyou considered it more appropriate for the Panel to follow up the subject. The Chairman suggested and members agreed that the subject would be included in the list of outstanding items for discussion.

III. Items for discussion at the next meeting
(LC Paper Nos. CB(2)258/11-12(01) and (02))

4. Members agreed to discuss the following items at the next regular meeting scheduled for 12 December 2011 at 8:30 am -

(a) Pilot Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector;

(b) electronic health record sharing; and

(c) monitoring of charging policy of private hospitals for obstetric services.

IV. Proposal for setting up a Health and Medical Research Fund
(LC Paper Nos. CB(2)258/11-12(03) and (04))

5. Secretary for Food and Health ("SFH") briefed members on the Administration's proposal to set up a Health and Medical Research Fund ("HMRF"), details of which were set out in the Administration's paper (LC Paper No. CB(2)258/11-12(03)).

Eligibility and assessment criteria

6. Mr CHAN Kin-por expressed support for the setting up of a HMRF. Holding the view that Hong Kong had the edge to pioneer health and medical research in Chinese medicine, he urged the Administration to further promote research and development in Chinese medicine. Noting that the Health and Medical Research Council ("the Research Council") would be expanded to cope with the expected increase in research items to be funded under HMRF, Mr CHAN asked whether consideration could be given to appointing experts in the Chinese medicine field to sit on the Research Council.

7. Mr CHAN Hak-kan expressed concern about the small number of research projects on Chinese medicine approved under the existing Health and Health Services Research Fund ("HHSRF") and Research Fund for the Control of Infectious Diseases ("RFCID"). He asked how the Administration could ensure that the Research Council and its Grant Review Board ("GRB"), the members of which were mainly experts in the field of Western medicine, could conduct an objective review of grant applications in Chinese medicine.

8. SFH responded that classification of research themes under HMRF was not based on whether the research proposal was in the field of Chinese or Western medicines. All research grant applications would be reviewed on the basis of their scientific merit, such as originality, significance of the research questions, quality of scientific content, and credibility of design and methods, etc. For research projects on Chinese medicine, they would be reviewed and assessed by experts in the field of Chinese medicine.

9. Dr PAN Pey-chyou considered it reasonable to consolidate the existing HHSRF and RFCID into a new HMRF. He urged the Administration to lower the grant application threshold so that small-scale local clinical studies proposed by frontline public hospital doctors, who lacked sponsorship and support from multinational pharmaceutical manufacturers, would also be funded under HMRF.

10. SFH advised that the setting up of the proposed HMRF was aimed to provide dedicated support for health and medical research activities, research infrastructure and research capacity building in Hong Kong, so as to reduce the

reliance on local higher education institutions for the conduct of health and medical research. While higher education institutions would only support research conducted by their researchers, funding opportunities under HMRF would be open to all local researchers irrespective of whether they were working in the academia or the public and private healthcare sectors. In addition, research fellowships would be awarded to eligible candidates covering a range of research areas and specialties and geared toward a variety of levels (e.g. post-doctoral fellows and clinical research fellows) on the advice of the relevant Expert Advisory Panels of the Research Council.

11. Pointing out that private hospitals had already derived hefty profits from their business, Ms Cyd HO expressed concern that providing support for research proposals submitted by researchers working in the private healthcare sector would enable the private hospitals concerned to make use of the grant to purchase expensive and advanced medical equipment. She asked how the Administration could monitor the approved research projects conducted by successful applicants from the private healthcare sector to ensure that the outputs and outcomes of the projects would bring benefits to the society.

12. SFH stressed that to be eligible for a grant, the proposed research project must demonstrate, among other things, high scientific merit, ethical acceptability, local applicability and value-for-money. Grants were intended to cover only direct costs attributable to the project or programme, and should not include indirect costs such as costs of providing the treatment to patients. In addition, all successful applicants and administering institutions would be required to keep an audit trail of budget spent. SFH further said that while HHSRF and RFCID had so far supported no grant applications from researchers working in the private healthcare sector, it could not be ruled out that private healthcare service providers would be more willing to enhance their research capacity and infrastructure in the future.

13. Ms Cyd HO did not subscribe to SFH's explanation. At the request of Ms HO, SFH undertook to provide further information to allay her concern in the Administration's paper to be submitted to the Finance Committee for seeking funding approval for the setting up of HRMF.

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14. Noting from paragraph 7 of the Administration's paper that Hong Kong had been relatively conservative in terms of its expenditure on health and medical research as a ratio to Gross Domestic Products ("GDP") (i.e. 0.11% in 2007), Dr Samson TAM expressed support for increasing the non-recurrent commitment of consolidated HMRF by $1,000 million to support the broadened scope for funding health and medical research in Hong Kong. He sought explanation for the low participation rate of healthcare professionals in the private and public healthcare sectors in research activities.

15. SFH explained that unlike researchers in the academia, frontline healthcare professionals whose primary job duties were to deliver healthcare services had to make use of their own time to undertake research activities to enhance healthcare practices.

16. Dr PAN Pey-chyou noted that only applications that had received written clearance from recognized ethics committees would be considered for funding. In the light of this, he asked whether consideration could be given to setting up a central ethics review committee at HA so as to obviate the need for staff of HA to go through the cumbersome ethics review process for multi-cluster clinical studies.

17. SFH advised that clinical research involving facilities, staff or patients of HA had to be approved by the Cluster Research Ethics Committee/Institute Review Board of the hospital/institution at which the study would be conducted. The HA Head Office Research Ethics Committee would, among other things, monitor and audit research governance in HA and handle appeals against decisions of the Cluster Research Ethics Committee/Institute Review Board.

18. Mr CHAN Hak-kan queried whether researchers from the medical schools of the two local universities would have an advantage over those researchers from other higher education institutions in obtaining funding support from HMRF.

19. SFH replied in the negative, adding that there were a number of research projects conducted by researchers from the School of Chinese Medicine of the Hong Kong Baptist University, The Hong Kong Polytechnic University and The Hong Kong University of Science and Technology under the existing HHSRF and RFCID.

20. Mr CHAN Hak-kan considered that to ensure transparency of the assessment process, the Research Council should provide the unsuccessful applicants with the reasons for rejecting their grant applications.

21. Expressing support for the setting up of a HMRF, Mr Andrew CHENG considered it important to ensure openness, fairness and transparency of the research grant review process.

22. Scientific Review Director (Research Office) advised that research projects to be funded by HMRF would continue to be subject to the stringent two-tier peer review process established for HHSRF and RFCID, i.e. first by a Referee Panel comprising local and overseas expert referees, and then by GRB acting as a scientific advisor to the Research Council. Together they would access the scientific merit of the research projects and consider other objective assessment criteria such as research ethics and value for money. GRB would

then make recommendation on funding applications for consideration and endorsement by the Research Council. Both the successful and unsuccessful applicants would be provided with comments from GRB and/or Referees.

Funding support provided under HMRF

23. Expressing support for subsuming the existing HHSRF and RFCID into HMRF, Dr Joseph LEE sought information on the estimated annual cash flow requirement for the new commitment of $1,415 million for setting up a HMRF, which made up of an allocation of $1,000 million plus the unexpended balances of HHSRF and RFCID.

24. SFH responded that based on the experience of HHSRF and RFCID, the funding requirement for supporting research under HMRF was estimated to be about $250 million per annum. The exact cash flow requirements over the coming years was difficult to estimate as these depended on the number of applications submitted and projects approved each year and the expenditure pattern for individual projects. It was expected that the injected commitment would be able to support local health and medical research projects and activities, research capacity building initiatives, and research infrastructure and facilities over the next five years or longer.

25. Ms LI Fung-ying expressed support for the setting up of HMRF by consolidating the existing HHSRF and RFCID. She asked whether there would be a grant ceiling for each project approved under HMRF so that a wider spectrum of research with maximum possible coverage of both large-scale and small-scale studies could be funded.

26. SFH advised that for the existing HHSRF and RFCID, the normal grant ceiling for any single project was $1 million. Higher grants might be considered where justified, such as multi-centre collaborations and projects or medical research infrastructure commissioned by the Government on specific public health issues or themes. There had been cases that approved projects having high scientific merit were able to obtain additional funding from other sources, such as academic institutions and pharmaceutical manufacturers, in the course of research. It was proposed that the same grant ceiling of $1 million would be imposed on projects approved under HMRF.

27. Dr Samson TAM asked whether consideration could be given to raising the grant ceiling so as to attract more researchers to engage in health and medical research activities. Mr Andrew CHENG held the view that the Administration should flexibly handle those research applications which required a greater amount of financial support. Ms Cyd HO considered that funding of $1 million might not be adequate for large-scale research.

28. SFH advised that setting the grant ceiling for single individual research project at $1 million was considered appropriate. For cases such as multi-centre collaborations and projects or medical research infrastructure, higher grants would be considered where justified.

Governance and administration of HMRF

29. Dr Joseph LEE sought elaboration on the annual operation costs of HMRF, which according to the Administration would take up about 1.4% of the total fund, and the projected increase in the staff establishment of the Research Fund Secretariat after the set up of HMRF.

30. Deputy Secretary for Food and Health (Health) 2 ("DSFH(H)2") advised that the administrative costs for the operation of HMRF would include staff cost of the HMRF Secretariat and expenses for other activities necessary to support the administration and operation of HMRF. Apart from the direct operation costs which would be charged to HMRF, most of the costs (including costs of staff overseeing and supporting the governance and administration of HMRF and overhead costs) would be absorbed by the Food and Health Bureau. DSFH(H)2 further advised that the Bureau's Research Office currently comprised 15 full-time staff and served as the Research Fund Secretariat to support the operation of HHSRF and RFCID, including processing of grant applications, arranging the release of funds, monitoring on-going projects, disseminating research project results, and conducting post-completion assessment to evaluate the research outputs and outcomes. To cope with an expected two and a half to three fold increase in the number of grant applications and research items to be funded due to the broadened scope of HMRF, the Research Office would be augmented by 10 to 13 non-directorate staff. DSFH(H)2 stressed that a lower staff to projects ratio had been adopted when projecting the increase in staff establishment.

31. Ms LI Fung-ying requested the Administration to provide information on the present staff establishment of the Research Fund Secretariat and the projected increase in the staff establishment of the Secretariat after the set up of HMRF (including their respective ranks and duties) in its paper for the Finance Committee when seeking funding approval for the set up of HMRF.

32. DSFH(H)2 advised that the Research Fund Secretariat was currently headed by a Consultant, with the support of medical and health officer, scientific officers and supporting executive, clerical and secretarial grade staff.

Admin The Administration would provide the requisite information in its paper to be submitted to the Finance Committee for Members' reference.

33. Noting that the Research Council currently comprised only healthcare professionals in the academia and the public and private healthcare sectors,

the Chairman suggested that consideration could be given to appointing lay persons to the Research Council. Dr Samson TAM also held a similar view. SFH agreed to consider the suggestion.

Health expenditure

34. Mr CHAN Kin-por noted with concern from paragraph 7 of the Administration's paper that Hong Kong ranked the second lowest among the selected advanced economies in terms of the total health expenditure as a ratio to GDP in 2007 (i.e. stood at 4.8% and just higher than that of Singapore). He urged the Administration to increase the amount of public health expenditure to improve public healthcare services.

35. SFH responded that the Government had already pledged to increase the recurrent expenditure on health from 15% in 2007-2008 to 17% in 2012. However, given the strength of domestic economy in recent years, the total health expenditure as a share of GDP had remained at the level of 4% to 5% throughout. While agreeing that there was room for further increasing the resources for public healthcare services, the Administration had to ensure the prudent use of public money under the principles of small government and low tax regime. SFH further said that continuous efforts would be made to improve the software and hardware to support the development of the healthcare system through increasing the number of student places for doctors, nurses and healthcare disciplines; redeveloping the existing public hospitals; establishing new public hospitals; and facilitating the development of private healthcare services.

Conclusion

36. Concluding the discussion, the Chairman said that members of the Panel were in support of the proposal to consolidate the existing HHSRF and RFCID into a new HMRF, and increase the non-recurrent commitment of the consolidated HMRF by $1,000 million.

V. Mechanism for handling medical incidents in private hospitals

(LC Paper Nos. CB(2)258/11-12(05) and (06) and CB(2)309/11-12(01))

37. Deputy Secretary for Food and Health (Health) Special Duties ("DSFH(H)SD") and Principal Medical & Health Officer (1) briefed members on the mechanism for handling medical incidents in private hospitals, details of which were set out in the Administration's paper (LC Paper No. CB(2)258/11-12(05)) and the PowerPoint presentation materials tabled at the meeting (LC Paper No. CB(2)309/11-12(01)).

Effectiveness of the mechanism

38. Mr Fred LI pointed out that it would be extremely rare that the Director of Health would exercise the statutory power under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) ("the Ordinance") to cancel the registration of a private hospital in the event of a contravention of the specified conditions relating to accommodation, staffing or equipment. He asked how the Administration could effectively monitor the performance of private hospitals.

39. DSFH(H)SD advised that as the registration authority, the Department of Health ("DH") monitored the performance of private hospitals by conducting routine and surprise inspections. In addition, DH had issued a Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes ("the Code of Practice") in 2003 setting out the standards of good practice for private hospitals to adopt with a view to enhancing patient safety and quality of healthcare services. With effect from 1 February 2007, DH introduced a sentinel event reporting system for private hospitals, requiring all private hospitals to report to DH, within 24 hours of occurrence, medical incidents falling into specific categories of sentinel events.

40. Deputy Director of Health ("DDoH") agreed that the scope and depth of the existing Ordinance had failed to meet the rising public expectation for a mechanism that could effectively monitor the performance of private hospitals. The Administration would conduct a review on the Ordinance.

41. In response to Mr CHAN Hak-kan's enquiry about the scope of the review of the Ordinance, DSFH(H)SD advised that the focus of the review would be on enhancing the service standards and pricing transparency of private hospitals. Mr Andrew CHENG asked whether consideration could be given to immediately increasing the penalty for offences under the Ordinance to enhance the deterrent effect. DSFH(H)SD responded that the review would cover, among other things, the penalty system.

42. Mr Andrew CHENG considered that the Administration should establish an independent statutory Office of Health Service Ombudsman to investigate into the sentinel event occurred in private hospitals, with a view to ensuring that the affected patients would be properly compensated.

43. DSFH(H)SD advised that at present, complaints against private hospitals could be lodged with DH. In addition, members of the public who considered that a healthcare professional had breached the professional conduct could lodge complaints to the Medical Council of Hong Kong or other relevant healthcare professional regulatory bodies.

44. Dr PAN Pey-chyou pointed out that the Hong Kong Private Hospitals Association had recently strictly required medical practitioners with admission or practicing privilege to take out Professional Indemnity Insurance managed by a mutual medical protection society which was not registered in Hong Kong. The medical practitioners had expressed concern that the society was not subject to the regulation of the Office of the Commissioner of Insurance. He did not subscribe to the Administration's view that it should not intervene with the requirement imposed by the Hong Kong Private Hospitals Association under the principle of professional autonomy

45. DDoH responded that for the purpose of protecting public health, the Administration would keep in view of the development of the matter to assess whether the interests of the public would be undermined.

46. Pointing out the long lead time required by the Administration to review and introduce legislative amendments to the Ordinance, Ms Audrey EU asked whether the Administration had put in place any administrative measures, such as a penalty system and disciplinary actions, to effectively regulate the performance of private hospitals in the interim.

47. DDoH advised that at present, public announcement on individual sentinel events would be made by DH if the event was of significant public health impact or ongoing public health risk. This would put pressure on private hospitals to reduce the likelihood of recurrence of such event in the future. In addition, the Administration would, after consulting the Department of Justice, notify the relevant healthcare professional regulatory bodies any medical incidents involving a breach of professional conduct. In the meantime, the Administration would continue its effort to strengthen mutual communication, publicity and education and to keep a close monitor on the private hospitals, having regard to the growing public expectation for private hospitals to provide quality services and DH to fulfil its role as the regulator.

Sentinel event reporting system for private hospitals

48. Mr CHEUNG Man-kwong noted with concern from Annex B to the Administration's paper that the number of reported sentinel events in private hospitals had dropped significantly from 39, 33 and 52 cases in 2007, 2008 and 2009 to 10 and three cases in 2010 and 2011 (as at 27 October 2011). Holding the view that the Ordinance and the sentinel event reporting system were paper tigers carrying penalty systems without sufficient deterrent effect, he surmised that the main reason why there was a declining trend in the number of reported sentinel events was that private hospitals did not adhere to the requirement of reporting all sentinel events to DH.

49. DDoH responded that while DH was aware of the declining trend in the number of reported sentinel events in private hospitals, the routine and surprise inspections conducted by DH as well as the complaints lodged by the general public against private hospitals showed no evidence of any hidden cases of reportable sentinel event. The fact that a number of public hospital doctors had joined the private hospitals in recent years might be one factor contributing to the enhancement of capability of private hospitals. DDoH further advised that private hospital which was found guilty of an offence under the Ordinance would in respect of each offence be liable on summary conviction to a fine of $1,000.

50. Referring to a recent medical incident in a private hospital which was not being reported to DH within the required timeframe under the sentinel event reporting system, Mr CHAN Hak-kan was concerned about the discrepancies in the interpretation of reportable sentinel events between the Administration and the private hospitals.

51. DDoH responded that discrepancies in the interpretation of reportable events would be addressed through enhanced communication, publicity and public education. The Administration would also review regularly the implementation of the sentinel event reporting system.

52. Dr Joseph LEE sought explanation why the Administration did not require private hospitals to follow the Sentinel Event Policy of HA but allowed them to develop their own policies and mechanisms to identify, report and manage sentinel events. In his view, this might result in private hospitals not reporting to DH all sentinel events occurred.

53. DDoH said that there was no cause for such concern, as the categories of sentinel events required to be reported by private hospitals had been clearly defined under the sentinel event reporting system for private hospitals. The Code of Practice had also set out the requirements for the management of serious medical incidents by private hospitals. While the existing Ordinance only empowered the Director of Health to register private hospitals subject to conditions relating to accommodation, staffing or equipment, DDoH assured members that the review of the Ordinance would take into account the rising public aspiration for a broader scope of regulation over private hospitals.

54. Mr Albert HO enquired whether the Administration had the statutory power to investigate into sentinel events of private hospitals. DDoH responded that under the existing Ordinance, the investigation power of DH was confined to issues relating to the accommodation, staffing or equipment of the private hospitals. Mr Albert HO was of the view that the Administration should not develop the medical industry in Hong Kong when it lacked an effective and comprehensive regulation over private hospitals.

55. The Chairman enquired whether cases of sentinel events in private hospitals involving unanticipated death during or shortly after operation or interventional procedure, maternal death and perinatal death were required to be reported to coroner's court. DSFH(H)SD replied in the affirmative.

VI. Financial assistance to needy patients to meet expenses on privately purchased drugs

(LC Paper Nos. CB(2)258/11-12(07) and (08))

56. Principle Assistant Secretary for Food and Health (Health) 2 ("PASFH(H)2") briefed members on the financial assistance to needy patients to meet expenses on privately purchased drugs, details of which were set out in the Administration's paper (LC Paper No. CB(2)258/11-12(07)).

Eligibility criteria for financial assistance

57. Noting that applicants for the Samaritan Fund ("SMF") had to pass a household-based financial assessment, Mr CHAN Hak-kan asked whether consideration could be given to allowing patients living with their family members to apply for assistance on an individual basis. Ms Audrey EU raised a similar question, adding that drug expenses incurred by chronic patients should be tax deductable.

58. Director (Cluster Services), HA explained that the rationale for requiring patients who were living with family members to apply for SMF on a household basis was to encourage family members to support each other. The same principle was adopted for applications for Comprehensive Social Security Assistance, legal aid and education subsidies. The Administration had no intention to change its policy of requiring patients to apply for SMF on a household basis at this stage. Nonetheless, the Administration noted members' views and would keep in view the matter.

59. While welcoming the introduction of the Community Care Fund ("CCF") Medical Assistance Programme, Ms Cyd HO was concerned that retired persons having no income but a self-occupied property would still not be eligible for assistance under SMF.

60. Director (CS), HA advised that the flat owned and resided in by the patient's household and the tools of trade of the patient's household would be excluded from the calculation when assessing the financial conditions of the patients under SMF.

61. Citing a case whereby a self-financed target therapy drug for the treatment of breast cancer had costed the middle-class patient concerned over

$20,000 a month as an example, Mr Albert HO asked whether the second CCF Medical Assistance Programme to be rolled out in the first quarter of 2012 would adopt a less stringent criteria so that more needy HA patients could be provided with financial assistance to meet their expenses for self-financed drugs.

62. Director (CS), HA advised that at present, the first programme of CCF would provide subsidy to needy HA patients for the use of six specified self-financed cancer drugs for seven specific cancer diseases that had not yet been brought into the safety net of Samaritan Fund. The number of cancer drugs to be covered might be increased in the future. The second programme of CCF would adopt more relaxed means test criteria than those for the Samaritan Fund, so as to benefit those patients who marginally fell outside the safety net of Samaritan Fund for the use of drugs subsidized by the Samaritan Fund. In addition, the drugs assistance schemes run by community pharmacies operated by non-government organizations or charitable funds in the community could also provide financial assistance for means-tested patients to purchase self-financed drugs in the Drug Formulary of HA ("the Formulary"). Mr Albert HO requested HA to provide written information on the drugs assistance schemes in the community.

HA/ Admin

63. Ms LI Fung-ying held the view that HA should actively provide needy patients with the contact information and the eligibility criteria of the drugs assistance schemes in the community.

64. Director (CS), HA responded that consideration could be given to providing information on these drugs assistance schemes on the website of HA after obtaining the consent of the organizations concerned. He further said that information on SMF and the CCF Medical Assistance Programme were already provided at public hospitals and on the website of HA.

Drugs included in the Formulary or supported by SMF and CCF

65. Mr CHAN Hak-kan asked whether consideration could be given to introducing more target therapy drugs for treating cancers as general drugs or special drugs in the Formulary. He further sought explanation for non-inclusion of drugs for liver cancer in the Samaritan Fund and the CCF Medical Assistance Programme.

66. Director (Cluster Services), HA advised that the review on drugs would follow an evidence-based approach having regard to the principles of efficacy, safety and cost-effectiveness. In recent years, HA had been expanding the clinical applications of the target therapy drugs for the treatment of cancers and rheumatoid arthritis. As regards treatment for liver cancer, drugs were considered less desirable than other treatment options available.

67. Mr CHEUNG Man-kwong considered that all life-saving drugs with proven efficacy should either be provided by HA at standard fees and charges, or covered under SMF or the CCF Medical Assistance Programme.

68. PASFH(H)2 advised that it had been the Administration's public healthcare policy to ensure that no one was prevented, through lack of means, from obtaining adequate medical treatment. HA had formulated the Formulary under the guiding principles that finite public resources should be utilized with maximal effect of healthcare, and had equitable access by all patients. The drug list in the Formulary was regularly reviewed under an established mechanism based on the scientific and clinical evidence on the safety, efficacy and cost-effectiveness of the drugs. At present, financial assistance was provided to needy patients in meeting expenses on self-financed drugs through SMF and CCF.

69. Mr Fred LI asked whether consideration could be given to including clotting factor concentrates and bypassing agents for treatment of haemophilia in the Formulary. Director (CS), HA responded that as a result of a recent review of the Formulary, HA would, among others, strengthen the preventive treatment for patients with haemophilia in the coming year.

Transparency of the Formulary

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

71. While agreeing that finite public resources should be utilized with maximal effect of healthcare, Ms Audrey EU stressed the need to enhance transparency of the Formulary by making public the reasons for the decisions on the introduction of new drugs and review of existing drugs in the Formulary. Consideration could also be given to allowing pharmaceutical manufacturers concerned to give an oral presentation to HA's Drug Advisory Committee when evaluating new drugs for incorporation into the Formulary.

72. Director (CS), HA advised that subsequent to the discussion with the Panel on the Formulary at the meeting in February 2011, HA had taken heed of members' views and uploaded to HA's website the decisions of its Drug Advisory Committee on individual applications for new drug evaluation, together with a list of reference that had been taken into account in the process of consideration of the applications.

Community pharmacies

73. Dr PAN Pey-chyou considered that the set up of community pharmacies operated by non-government organizations would benefit patients by avoiding

monopoly of large chain pharmacy groups. He asked whether consideration could be given to providing assistance to these pharmacies in the procurement of drugs and stepping up publicity to raise the awareness of patients and doctors in the work of community pharmacies.

74. Director (CS), HA responded that to his understanding, the community pharmacies operated by non-government organizations had put in place drugs assistance schemes to provide financial assistance for means-tested patients to purchase self-financed drugs in the Formulary. A definition of what constituted community pharmacies had to be hammered out before HA could explore whether it should help to promote the work of community pharmacies. PASFH(H)2 supplemented that the Administration would explore ways to enhance assistance to needy patients to meet their expenses on privately purchased drugs.

VII. Any other business

75. The Chairman reminded members that a special meeting had been scheduled for 24 November 2011 to discuss with the Administration on the "Health Protection Scheme".

76. There being no other business, the meeting ended at 10:35 am.

Council Business Division 2
Legislative Council Secretariat
6 January 2012