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Legislative Council

LC Paper No. CB(2)963/11-12
Ref : CB2/PL/HS (These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 12 December 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 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 Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou Hon Alan LEONG Kah-kit, SC
Members absent	:	Hon CHEUNG Man-kwong Dr Hon Samson TAM Wai-ho, JP
Public Officers attending	:	Item IV Dr York CHOW Yat-ngok, GBS, JP Secretary for Food and Health

Mr Richard YUEN Ming-fai, JP
Permanent Secretary for Food and Health (Health)

Miss Janice TSE Siu-wa, JP
Head (eHealth Record)

Ms Lydia LAM Sui-ping
Deputy Head (eHealth Record)

Items V and VI

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

Item V

Dr W L CHEUNG
Director (Cluster Services)
Hospital Authority

Dr K M CHOY
Chief Manager (Service Transformation)
Hospital Authority

Dr CHAN Kam-hoi
Senior Manager (Transformation Projects)
Hospital Authority

Item VI

Dr Tina MOK
Principal Medical & Health Officer(1)
Department of Health

Attendance by invitation : Item VI

Hong Kong Private Hospitals Association

Dr Alan LAU Kwok-lam
Chairman

Clerk in attendance : Ms Alice LEUNG
Chief Council Secretary (2) 5 (Acting)

Staff in attendance	:	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

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I. Confirmation of minutes

(LC Paper No. CB(2)497/11-12)

The minutes of the special meeting held on 20 October 2011 were confirmed.

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

(LC Paper Nos. CB(2)391/11-12(01), CB(2)395/11-12(01), CB(2)438/11-12(01) and CB(2)439/11-12(01))

2. Members noted the following papers issued since the last meeting -

(a) joint submission dated 18 November 2011 from 57 organizations in the Chinese medicines trade expressing views on regulation of proprietary Chinese medicines;

(b) letter dated 15 November 2011 from Hong Kong Government Pharmaceutical Dispenser Association to the Chief Executive of Hospital Authority expressing views on the dispensaries of the General Outpatient Clinics of the Hospital Authority ("HA") manned by dispensers in the capacity of "approved persons";

(c) letter dated 14 November 2011 from The Practising Pharmacists Association of Hong Kong to the Chief Executive expressing views on recruitment of non-local doctors by HA to serve in public hospitals under limited registration; and

(d) letter dated 22 November 2011 from Alliance for Patients' Mutual Help Organizations to Chairman of Pharmacy and

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Poisons Board Hong Kong expressing views on clerkship programmes at schools of pharmacy.

III. Items for discussion at the next meeting

(LC Paper Nos. CB(2)460/11-12(01) and CB(2)498/11-12(01) and (02))

3. The Chairman referred members to Mr Albert HO and Mr CHEUNG Man-kwong's joint letter dated 30 November 2011 (LC Paper No. CB(2)460/11-12(01)) in which they had expressed concern over the frequent occurrence of medical incidents in Tuen Mun Hospital in recent months and requested the Panel to discuss the issue of management and healthcare manpower of Tuen Mun Hospital. He sought members' views on whether the subject should be discussed at the next regular meeting scheduled for 9 January 2012.

4. Dr Joseph LEE pointed out that apart from Tuen Mun Hospital, medical incidents had taken place in other public hospitals. He considered it more appropriate for the Panel to discuss the improvement measures to be put in place by HA with a view to avoiding the occurrence of medical incidents in public hospitals.

5. Referring to the recent media reports about the healthcare manpower shortage of the Medicine specialty of the Untied Christian Hospital, Dr PAN Pey-chyou said that HA should also be requested to address this issue during the discussion of the item. Ms LI Fung-ying concurred with Dr LEE's and Dr PAN's suggestions.

6. Ms Audrey EU said that to facilitate consideration as to whether manpower shortage in public hospitals was a factor contributing to the occurrence of serious medical incidents, HA should be requested to provide information on the existing establishment and shortfall of healthcare staff in each public hospital in the discussion paper for the meeting.

7. Summing up, the Chairman said that the Panel would discuss the subject of handling of medical incidents in public hospitals at its next regular meeting in January 2012. At the request of the Chairman, the Secretary for Food and Health ("SFH") agreed that the management of the Tuen Mun Hospital would attend the meeting to answer questions from members in relation to the recent medical incidents occurred in the Tuen Mun Hospital.

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8. SFH proposed that the item on "Proposed regulatory framework of medical devices" be discussed also at the next regular meeting of the Panel. Members agreed.

(*Post-meeting note:* At the request of the Administration and with the concurrence of the Chairman, a new discussion item on "Commencement of Undesirable Medical Advertisements (Amendment) Ordinance" had been added to the agenda for the meeting, and the discussion item "Proposed regulatory framework of medical devices" had been deferred to a future meeting.)

IV. Electronic health record sharing
(LC Paper Nos. CB(2)498/11-12(03) and CB(2)577/11-12(01))

9. SFH briefed members on the proposed legal, privacy and security framework for the Electronic Health Record ("eHR") Sharing System as detailed in the consultation document issued by the Administration on the day of the meeting for public consultation until 11 February 2012 and tabled at the meeting. Deputy Head (eHealth Record) then conducted a powerpoint presentation on the salient points of the framework, details of which were set out in the powerpoint presentation materials tabled at the meeting.

10. Dr PAN Pey-chyou expressed dissatisfaction that the consultation document was only provided to members at the meeting. He held the view that given the complexity of the subject, members should be allowed more time to study the issues involved to facilitate thorough discussion.

Data security and accuracy

11. Dr PAN Pey-chyou enquired whether the data in the eHR Sharing System would be stored in a centralized database maintained by the Administration to guard against data loss and damage.

12. SFH advised that a central data repository approach was adopted for eHR. The eHR Core architecture was based on a centralized eHR sharable data store and all data uploaded by participating healthcare providers to the central eHR data store would be transformed, restructured, standardized and re-formatted where appropriate before storage to the eHR Sharing System. Permanent Secretary for Food and Health (Health) ("PSFH(H)") supplemented that in addition to the primary eHR data centre, a secondary data centre would be established, so that two sets of synchronized data will be maintained to guard against data loss and damage.

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13. Mr CHAN Kin-por noted that the eHR Sharing System would comprise standalone electronic medical/patient record ("eMR/ePR") systems adopted by individual healthcare providers and a central electronic platform as the sharing infrastructure for such eMR/ePR systems to interconnect for sharing of eHR amongst them. He expressed concern about how the Administration could prevent system or data input errors in an individual eMR/ePR system from affecting the accuracy of the health data of patients available on the eHR Sharing System.

14. PSFH(H) responded that there was no need for such concern as the operation of HA's Clinical Management System ("CMS"), which provided valuable experience and expertise for sharing of medical/patient records among individual systems in various public hospitals and clinics, was smooth and no major problem had been identified so far. In case of inaccuracy in data input, healthcare professionals accessing the eHR data of the subject patient should be able to detect the error. PSFH(H) further said that the eHR Sharing System would be hosted in a secure platform with multiple firewalls, intrusion detection tools and industry leading encryption technology to support different application services and to protect the patients' health data. In addition, a comprehensive security and audit framework would be established to ensure safe and secure operation of the eHR Sharing System. The eHR Sharing System would also notify the patient, via a Short Message Service or other means, when his/her eHR was accessed to facilitate the reporting of suspected unauthorized access or use of eHR data.

15. The Chairman remained concerned, pointing out that there had been a case that even though a doctor of the Prince of Wales Hospital had immediately corrected an inaccurate entry of health data of a patient in CMS, the system failed to update the centrally-held medical record of the subject patient for retrieval by doctors of other public hospitals.

16. PSFH(H) stressed that it was the responsibility of the healthcare professionals to conduct data checks after inputting or correcting eHR data to ensure data accuracy. Under the eHR Sharing System, any amendment would be appended to eHR instead of replacing the original data. The changes or corrections made would also be highlighted in a mark-up or tracking mode for healthcare providers who subsequently accessed the relevant eHR to facilitate the tracing of the history of changes.

Participation in eHR sharing

17. Pointing out that some private medical practitioners, in particular those in solo practices, might lack the hardware and technical skills for connection to the eHR sharing platform, Mr CHAN Kin-por expressed

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concern about the participation of private healthcare providers in eHR sharing.

18. SFH responded as follows -

(a) most private hospitals had their own eMR/ePR or hospital information systems. All 12 private hospitals had indicated their interest in participating in the eHR Programme. The public-private-partnership pilot projects involving sharing of health data launched through HA had also enrolled thousands of private healthcare providers and more than 200 000 patients;

(b) medical graduates since 1990s who had worked in public hospitals should be familiar with electronic mode of storing and retrieving medical records of patients, as HA had progressively developed its CMS since 1995. Private medical practitioners affiliated with private hospitals also had the experience of using the hospitals' information systems; and

(c) efforts would be made to engage the Hong Kong Medical Association to promote eHR sharing in the clinical settings. Continuous effort was also being made to provide technical assistance to the private sector to, among others, develop eHR-compatible systems for private hospitals and clinics so as to facilitate development and adoption of eHR-compatible systems by private healthcare providers.

19. Ms LI Fung-ying pointed out that the Administration had agreed to consider creating incentives for healthcare providers to participate in eHR sharing. She enquired whether measures would be put in place to make eHR sharing attractive (e.g. capping costs of the hardware and software to be incurred by healthcare providers for adopting their own eMR/ePR system and connecting to the eHR sharing platform).

20. SFH responded that while the Administration would provide funding for the development of the eHR sharing infrastructure and clinic management software with sharing and integration capability, private healthcare providers would remain responsible for their own hardware for connecting to the eHR sharing platform. Given that the Administration had taken up the system development cost, the cost to be borne by private healthcare providers for joining eHR sharing should not be substantial. Training and technical support would also be provided to the private sector to facilitate their participation in eHR sharing.

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21. Mr WONG Ting-kwong considered that the introduction of eHR sharing would bring benefits to patients. He asked whether the Chinese medicine practitioners could participate in eHR sharing.

22. SFH replied that the Chinese medicine practitioners could not participate in eHR sharing at the initial stage. He, however, pointed out that HA currently maintained a common electronic clinical management system for sharing and collating clinical information among the 15 Chinese medicine clinics in the public sector. In addition, the Hong Kong Dental Association had developed a clinical management system for the dental sector. It was hoped that these systems would be able to utilize the shared services offered by the eHR core infrastructure in the future.

23. In response to Ms LI Fung-ying's enquiry about the data volume of the eHR Sharing System, SFH advised that the eHR Sharing System would be leveraged largely on the well-developed HA's CMS, which was probably one of the largest-scale integrated eMR/ePR systems of its kind in hospitals around the world. At present, HA's CMS had already accumulated the medical records of over nine million patients. The eHR Sharing System would be developed as a territory-wide system for the whole population of Hong Kong. It was designed in a scaleable manner so that its capacity could be readily expanded as and when necessary.

Scope of data for eHR sharing

24. Pointing out that patients at present often had difficulty in accessing the medical records kept by their private medical practitioners, Ms Audrey EU emphasized the need to enable patients to take greater ownership of their medical records under the eHR Sharing System. She asked whether the proprietary right of eHR would be vested in the participating healthcare providers or the subject patients. She also sought clarification on whether healthcare providers would be held legally liable for failing to input complete records of their patients under the eHR Sharing System. If this was not the case, it might give rise to the keeping of two different sets of health record of the enrolled patients by the same participating healthcare provider, i.e. a more comprehensive hand-written record and a less comprehensive sharable electronic record.

25. SFH stressed that while patients had the right to access their own medical records, healthcare professionals had the responsibility to maintain a complete and accurate set of medical records of their patients, regardless of whether they were recorded in paper or electronic form. Under the eHR Sharing System, healthcare providers participating in eHR had to upload the health data of the enrolled patients if it fell within the pre-defined scope for eHR sharing. Data that fell outside the scope of sharable eHR

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could be retained in the healthcare providers' paper records or their eMR/ePR systems without sharing with other healthcare providers through the eHR Sharing System.

26. Dr PAN Pey-chyou asked whether healthcare providers could, on the request of patients, conceal some categories of sensitive eHR sharable data, such as data relating to the mental health of the patients, from being automatically accessed by other healthcare providers.

27. SFH advised that the issue had been discussed by the Steering Committee on eHR Sharing which comprised, among others, healthcare professionals from both the public and private sectors and representatives from patient groups. It was decided not to put in place a safe deposit box for separate storage of certain patient data with enhanced access control on the grounds that it would undermine the completeness and integrity of patients' eHR and in turn affect the quality of care provided to patients. Dr PAN Pey-chyou remained of the view that given the sensitivity of some health data which warranted extra safeguards, a safe deposit box should be provided under the eHR Sharing System.

Directorate support for the Electronic Health Record Office

28. Mr WONG Ting-kwong enquired whether the two supernumerary directorate posts created in the Health Branch of the Food and Health Bureau to head the Electronic Health Record Office would be retained in the future.

29. PSFH(H) advised that the current supernumerary directorate posts were created in 2009 on a time-limited basis for four years. The Administration would take account of the development and implementation progress of the eHR programme when reviewing the continued need of these two posts in the long term.

Way forward

30. The Chairman suggested and members agreed that in view of the complexity of the subject and the time constraint, the Administration should revert to the Panel the outcome of the public consultation for further discussion. SFH agreed, adding that the Administration would provide members with further explanation or a demonstration of the eHR Sharing System during the interim period if necessary.

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V. Pilot Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector

(LC Paper Nos. CB(2)240/11-12(01) and CB(2)498/11-12(04))

31. Deputy Secretary for Food and Health (Health)2 ("DSFH(H)2") briefed members on the introduction of a two-year pilot initiative of HA to enhance radiological investigation services for patients from selected cancer groups through collaboration with the private sector ("the Pilot Project"), details of which were set out in the Administration's paper (LC Paper No. CB(2)240/11-12(01)). Director (Cluster Services), HA ("Director (CS), HA") highlighted the operational arrangements for the Pilot Project to be launched in the first quarter of 2012.

Target groups of the Pilot Project

32. Dr PAN Pey-chyou expressed support for the Pilot Project and said that radiological investigation services would facilitate cancer patients to receive timely diagnosis and proper treatment. Holding the view that there were other types of cancers (e.g. brain cancer, lung cancer and liver cancer) which also required radiological imaging for the assessment of cancer stages, he sought explanation on why only colorectal cancer, breast cancer, nasopharyngeal cancer and lymphoma were selected in the Pilot Project.

33. Director (CS), HA explained that the four cancer groups selected were based on the expert advice of clinicians and oncologists in HA in the light of the clinical needs of the patients from these cancer groups and the obvious demand for the radiological investigation services.

34. Dr PAN Pey-chyou further enquired whether considerations would be given to extending the scope of the Pilot Project to include other cancer groups and providing recurrent funding for the Pilot Project so that the project would be run on an ongoing basis.

35. DSFH(H)2 responded that an allocation of $65 million had been earmarked for the Pilot Project, which would be run on a time-limited basis starting from the first quarter of 2012 for two years. HA would evaluate the cost effectiveness of providing radiological investigation services through public-private-partnership for targeted patient groups and the quality of service provided by private sector providers. Based on the evaluation results and the experience from the implementation of the project, HA would review whether there were areas that could be improved, including target groups of the project and consider the way forward.

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Purchasing radiological investigation service from the private sector

36. While expressing support for the Pilot Project, Prof Patrick LAU was concerned that there was a significant difference in the charges of the radiological investigation service between the public and private sectors and the funding of $65 million earmarked for the Pilot Project might not be sufficient. Dr PAN Pey-chyou considered that the Administration should obtain a favourable offer in outsourcing the radiological investigation service to the private sector given the large volume of service required. Mr Alan LEONG sought information on the details of the open tender for the service provided by the private sector through public-private-partnership.

37. DSFH(H)2 responded that the objective of the Pilot Project was to provide enhanced radiological investigation services through collaboration with private sector providers for patients from four selected cancer groups under the care of HA. Under the Pilot Project, HA would provide full subsidy to the participating patients for receiving radiological investigation services at the designated private service providers. HA would identify suitable service providers and obtain a reasonable service charge through an open tender exercise scheduled for end 2011. HA would review the operational arrangements six months after implementation of the project. DSFH(H)2 further advised that an Invitation for Expression of Interest ("EoI") exercise had been conducted earlier to solicit market interest in the participation of the project. It was noted that there was adequate service capacity in the private sector that could be provided to the patients in the public sector through the public-private-partnership in the form of service purchasing.

38. Director (CS), HA supplemented that the response from private market was positive to the Pilot Project in the EoI exercise. Private diagnostic imaging centres would be selected through an open tender, based on the professional level of their services, radiologists, as well as machines and equipments. Clinical performance of the awarded providers would be evaluated according to a pre-defined set of performance indicators.

Service delivery

39. Prof Patrick LAU asked whether the implementation of the Pilot Project could help relieve the queue for radiological investigation service in the public hospitals. Dr Joseph LEE also enquired whether the waiting time of patients other than the four selected cancer groups for radiological investigation service would be shortened.

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40. Director (CS), HA responded that the implementation of the Pilot Project could assist eligible patients if they choose the radiological investigation services provided by the designated private service providers. In the light of this, those non-eligible patients would also be benefited indirectly. He also advised that participation of eligible patients in the Pilot Project was voluntary. HA would continue to provide radiological investigation services for those who chose to receive the service in pubic hospitals. HA hoped that most of the eligible patients would choose to participate in the Pilot Project for the purpose of receiving earlier diagnosis and timely treatment.

Admin 41. Dr Joseph LEE requested the Administration to provide data on the average waiting time of cancer patients for radiological investigation services before and six months after implementation of the Pilot Project.

42. In response to Mr Alan LEONG's enquiry about the timing in the delivery of radiological investigation services provided by private service providers, Director (CS), HA advised that participating patients would be coordinated through HA to have their staging/re-staging scans conducted at one of the designated private service providers under the Pilot Project. Radiological investigation services would normally be provided within one week upon the request for service made by HA. The private service providers were required to transfer the radiological images and radiologists' reports to HA through an electronic platform in five working days, so that HA doctors could formulate subsequent care and treatment plan for their patients.

43. Pointing out that there was presently a shortage of radiologists in public hospitals, Dr Joseph LEE was concerned that the provision of radiological investigation services through public-private-partnership might drive an increasing number of radiologists in HA switching to the private sector and thus aggravated the problem of shortage of radiologists.

44. Director (CS), HA agreed that there was at present a shortage of radiologists in public hospitals. However, given that the Pilot Project would only make use of the marginal capacity of the private diagnostic imaging centres, and the present scale of the Project, the headcount of qualified radiologists as well as the machinery and equipments should not be much affected. The Administration would monitor the impact on the manpower of radiologists in its review of the Pilot Project.

New cancer cases in Hong Kong

45. Mr CHAN Kin-por expressed support for the Pilot Project. Noting from Annex A to the Administration's paper that the demand for

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radiological imaging services in HA was increasing as a result of the rise in cancer cases over the years, he raised concern on the upsurge in the number of new cancer cases, especially in the age groups of 45 to 64 and 65 or above. He asked whether the Administration would conduct any study to better understand the causes of the increase in cancer cases and take initiatives to arouse public concern on the prevention of cancers.

46. DSFH(H)2 advised that the increase in the number of new cancer cases was partly due to an aging population. Both the Department of Health ("DH") and HA had been monitoring the development trend of cancers. At the policy level, under the Strategic Framework for Prevention and Control of Non-communicable Disease, the risk factors of cancers as a non-communicable disease were identified in the study on the rates of cancer cases in different age group. Measures and promotion to prevent and control non-communicable diseases were also taken. Director (CS), HA supplemented that colorectal cancer and breast cancer had the highest growth rate among the new cancer cases, and unhealthy lifestyle and eating habits were the two major contributing factors to these cancers.

VI. Monitoring of charging policy of private hospitals for obstetric services

(LC Paper Nos. CB(2)498/11-12(05) and (06))

47. DSFH(H)2 and Principal Medical & Health Officer(1), DH ("PMHO(1), DH") briefed members on the regulation and the charging policy of private hospitals for obstetric services, details of which were set out in the Administration's paper (LC Paper No. CB(2)498/11-12(05)).

Charitable status of private hospitals

48. While considering that prosperous development of private hospitals in recent years was conducive to the development of the medical industry in Hong Kong, Dr PAN Pey-chyou held the view that private hospitals should not be recognized as charitable organizations for tax exemption purpose. He pointed out that private hospitals had derived hefty profits from their business, partly due to the difficulty for new entrants to enter the market. To his understanding, some private hospitals had paid huge amount of bonuses to their staff members, thus attracting an increasing number of healthcare professionals in the public sector switching to private hospitals. He enquired whether the Administration had required private hospitals to provide their financial information in respect of their business, including costs, expenditures and net profits.

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49. Mr CHAN Kin-por urged the Administration to look squarely at the problems arising from the practice of some tax-exempt private hospitals to pay bonuses to their staff members which, in his view, was a grey area under the Inland Revenue Ordinance (Cap. 112) ("IRO"). Apart from causing further brain drain from the public to private hospitals, the practice would also lead to an increase in staff costs, thus pointing to the need to increase the level of service charges. He asked whether DH would consider issuing guidelines to remind those private hospitals that their profits should apply solely for charitable purposes.

50. DSFH(H)2 explained that an entity, including a private hospital, might be granted tax exemption if it was accepted by the Inland Revenue Department ("IRD") as a charitable institution or trust of a public character under section 88 of IRO. As required by IRD, charitable bodies applying for tax exemption had to have a governing instrument which stated their objects precisely and clearly. For charitable bodies granted tax exemption, their incomes (including profits derived from their business) and properties might only be used for attainment of their stated objects and any distribution of their incomes and properties amongst their members was strictly prohibited. IRD would review charitable bodies granted tax exemption regularly to see whether their objects were still of a charitable nature and whether their activities were compatible with their stated objects.

51. As regards the regulation of private hospitals under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) ("the Ordinance"), DSFH(H)2 advised that DH had no statutory power to regulate the level of charges of private hospitals. Its power to monitor the financial return or service scope of private hospitals was also limited.

52. Dr PAN Pey-chyou maintained the view that there was a need for the Administration to closely monitor those private hospitals which were granted tax exemption in accordance with section 88 of IRO to ensure that their profits were applied for charitable purposes. He pointed out that no other charitable institutions could apply for the grant of land for development at nominal or concessionary premium and derive such hefty profits from their business. He sought information on the proportion of profits used by these private hospitals for charitable purposes.

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53. The Chairman requested the Administration to provide after the meeting financial information related to the business of the private hospitals for the past five to 10 years.

54. DSFH(H)2 responded that the Administration considered it inappropriate to disclose confidential financial information of a charitable

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organization submitted to IRD for the purpose of reviewing its tax exemption status. The Administration would explore whether any relevant information submitted by the private hospitals to DH for renewal of registration under the Ordinance could be provided to members for reference.

55. Ms Audrey EU noted that among the 12 private hospitals registered in accordance with the Ordinance, 10 were charitable institutions which were exempted from tax under IRO. She sought information on which two private hospitals had not acquired tax exemption status as charitable organizations. DSFH(H)2 responded that the two private hospitals were the Hong Kong Sanatorium and Hospital and the Shatin International Medical Centre Union Hospital. In response to Ms Audrey EU's further enquiry on whether the 10 tax-exempt private hospitals could withdraw their tax exemption applications, DSFH(H)2 replied that these private hospitals were not required by their licensing condition to have such tax exemption status.

56. The Chairman sought clarification on whether there was a condition in the land grants made to the 10 private hospitals at nominal or concessionary premium prohibiting them from making profits.

57. Dr Alan LAU of Hong Kong Private Hospitals Association advised that other than the Hong Kong Central Hospital, the site of which was rented to the Hospital by Hong Kong Sheng Kung Hui, the operators of the other nine private hospitals were given land grant of the sites concerned at nominal or concessionary premium. All these 10 private hospitals were required to operate on a non-profit-making basis. As regards the Shatin International Medical Centre Union Hospital which was run by a private enterprise, the Hospital had once changed its status from profit-making to non-profit-making and resumed its profit-making status later.

58. Referring to the media reports about the reserves kept by the Hong Kong Baptist Hospital and the St. Teresa's Hospital which amounted to about $2 billion respectively, Dr Alan LAU of Hong Kong Private Hospitals Association stressed that private hospitals had to run their business without any Government subsidy to tide over difficult times, such as the SARS period in 2003. The reserves held by the above two hospitals could only fund their recurrent expenditures for two years. Dr Alan LAU also pointed out that where necessary, private hospitals had to make use of their reserves to buy pieces of land to expand their services, such as the case of the Hong Kong Baptist Hospital.

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Monitoring of services of private hospitals

59. While agreeing that it was not appropriate for the Administration to regulate the level of charges of private hospitals, Ms Audrey EU enquired whether consideration could be given to requiring purchasers or grantees of lands for private hospital development to comply with special land lease conditions with a view to ensuring diversity and quality of services provided by the private hospitals.

60. DSFH(H)2 advised that at present, private hospitals were subject to regulation by DH under the Ordinance on matters of accommodation, staffing or equipment. To ensure the provision of quality healthcare services to patients, DH had formulated a "Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes" ("the Code of Practice") in which the standards of good practices were set out for adoption by private hospitals. These standards included the need for a private hospital to ensure that services provided were of quality and appropriate to the needs of patients, requirements on the management of staff, premises and services, protection of the rights of patients and their right to know and the setting up of a system to deal with complaints.

61. DSFH(H)2 further said that the Administration was conducting a strategic review on healthcare manpower planning and professional development with a view to ensuring the sustainable development of the healthcare system to cope with increasing demand for healthcare services. When disposing of the four pieces of land reserved for private hospital development (at Wong Chuk Hang, Tseung Kwan O, Tai Po and Lantau respectively), the purchasers or grantees would be required to comply with lease conditions which included a set of special requirements on aspects such as bed capacity, scope of service and price transparency. In addition, a key feature of the Health Protection Scheme as a supervisory framework for private health insurance was to promote transparent medical fees with packaged charging for common procedures, so as to enhance transparency and competition of private healthcare services, among others. The Administration would also consider prudently the need to amend the Ordinance to better regulate the services of private hospitals.

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

Obstetric services provided by private hospitals

63. Ms LI Fung-ying expressed concern that some private hospitals had increased their charges for obstetric service on admission before delivery.

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She urged the Administration to enhance regulation over private hospitals. DSFH(H)2 reiterated that the Administration had no statutory power to intervene the level of charges of private hospitals.

64. Ms Cyd HO cited a case whereby a pregnant woman who had signed up for the maternity package at a private hospital was required to pay extra fees for various items upon delivery, including a registration fee which she had not been informed in advance. Noting that the Administration had no statutory power to regulate the level of charges of private hospitals, she asked whether there was any avenue for the aggrieved pregnant women to seek redress.

65. DSFH(H)2 advised that DH would follow up and investigate any complaints received on services provided by private hospitals. Ms Cyd HO considered that the Administration should actively monitor the local media reports on unreasonable practices of private hospitals in charging the pregnant women and take the initiative to follow up the cases.

66. Noting that the items covered by the maternity packages of private hospitals offering obstetric services varied among hospitals, Ms Cyd HO asked whether consideration could be given to requiring these private hospitals to set out against a standardized list the items or services covered by their maternity packages so as to enable expectant mothers to make an informed choice.

67. DSFH(H)2 advised that while the Administration had no statutory power to regulate the charges of private hospitals, the Code of Practice required private hospitals to, among other things, have a schedule of charges for reference by the public. For those services at packaged pricing, hospitals could decide on their own the items to be covered by the package.

68. Ms LI Fung-ying pointed out that most of the private hospitals did not provide neonatal intensive care service and newborns requiring intensive care in private hospitals would be transferred to public hospitals for treatment. She was concerned that the expansion of obstetric service by the private sector in the midst of the rising service demand from non-local women would create considerable strain on local obstetrics and neonatal services.

69. Dr Joseph LEE asked whether, and if so, what mechanisms were put in place by DH to ensure the provision of reasonably priced, adequate and priority private obstetric services for local pregnant women.

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70. DSFH(H)2 and PMHO(1), DH responded as follows -

(a) it was the Government's policy to ensure that Hong Kong residents were given proper and adequate obstetric services. HA would reserve sufficient places in public hospitals for delivery by local pregnant women and would only accept booking from non-local pregnant women when spare service capacity was available. While the Administration had no statutory power to regulate the target users of private hospitals, private hospitals offering obstetric services had agreed to provide sufficient services for local pregnant women by reducing bookings from non-local pregnant women based on their individual circumstances;

(b) the measure to cap the number of non-local pregnant women allowed to give birth in Hong Kong in 2012 introduced by the Administration earlier on could ease the tremendous pressure on the overall obstetric and neonatal care services. DH would collect information on a regular basis to monitor the number of bookings for deliveries by non-local women made with private hospitals against the agreed numbers; and

(c) when conducting inspections to private hospitals to monitor the compliance of their operation with the Ordinance and the Code of Practice, DH would, among others, ensure that the hospitals had a schedule of charges, including package prices, available for reference by patients. It was also found that many private hospitals had publicized their schedules of charges on the hospitals' websites.

71. In response to Dr Joseph LEE's enquiry on whether DH would consider publishing the pricing information of private hospitals on its websites for reference of members of the public, PMHO(1), DH said that it would be more appropriate for the private hospitals concerned to publish and update their pricing information.

VII. Any other business

72. There being no other business, the meeting ended at 10:45 am.

Council Business Division 2
Legislative Council Secretariat
7 February 2012