立法會
Legislative Council

LC Paper No. CB(2)1287/11-12

Ref : CB2/PL/HS (These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 9 January 2012, 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 Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou Hon Alan LEONG Kah-kit, SC
Member absent	:	Dr Hon Samson TAM Wai-ho, JP
Public Officers attending	:	Items IV and V Miss Janice TSE Siu-wa, JP Deputy Secretary for Food and Health (Health)1

Item IV

Dr W L CHEUNG
Director (Cluster Services)
Hospital Authority

Dr LIU Hing-wing
Director (Quality & Safety)
Hospital Authority

Dr Albert C Y LO
Cluster Chief Executive, New Territories West Cluster /
Hospital Chief Executive, Tuen Mun Hospital
Hospital Authority

Dr Tony KO
Chief Manager (Patient Safety & Risk Management)
Hospital Authority

Item V

Dr Gloria TAM, JP
Deputy Director of Health

Dr Teresa LI
Principal Medical & Health Officer(5)
Department of Health

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

Miss Liza LAM
Clerical Assistant (2) 5

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I. Confirmation of minutes

(LC Paper No. CB(2)711/11-12)

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

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

(LC Paper No. CB(2)705/11-12(01))

2. Members noted that the letter dated 23 December 2011 from the Hong Kong Infant and Young Child Nutrition Association to the Secretary for Food and Health expressing views on consultation on the draft Hong Kong Code of Marketing of Breastmilk Substitutes had been issued since the last meeting.

III. Items for discussion at the next meeting

(LC Paper Nos. CB(2)712/11-12(01) and (02))

3. Members agreed to discuss the following items at the next regular meeting scheduled for 13 February 2012 at 8:30 am -

(a) Health Protection Scheme; and

(b) tobacco control – progress update.

IV. Handling of medical incidents in public hospitals

(LC Paper Nos. CB(2)712/11-12(03) and (04))

4. Deputy Secretary for Food and Health (Health)1 ("DSFH(H)1") and Director (Quality & Safety), Hospital Authority ("Director(Q&S), HA") briefed members on the mechanism for handling medical incidents in public hospitals and the relevant clinical governance structure in the Hospital Authority ("HA"), details of which were set out in the Administration's paper (LC Paper No. CB(2)712/11-12(03)).

Reporting of medical incidents

5. Noting the discrepancies in the types and the descriptions of reportable sentinel events between the public and private hospitals, Mr CHAN Hak-kan sought explanation for putting in place two mechanisms for the reporting of medical incidents.

6. DSFH(H)1 explained that while two reporting systems were being put in place, both public and private hospitals were required to report sentinel events

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within 24 hours upon occurrence of the event and conduct investigations into the event for root cause identification and implementation of improvement measures. A pilot scheme of hospital accreditation was launched in May 2009 with a view to developing a territory-wide hospital accreditation scheme in Hong Kong. A key objective of the pilot scheme was to develop a set of common hospital accreditation standards for measuring the performance of both public and private hospitals in various aspects in the long run. This included, among others, the management of medical incidents and complaints. Five public hospitals and three private hospitals had joined the pilot scheme. All of them had been awarded the four-year accreditation status.

7. Mr Alan LEONG asked whether the Administration would speed up the implementation of the hospital accreditation programme.

8. DSFH(H)1 responded that efforts had been and would continue to be made to encourage more hospitals to participate in the accreditation programme. Director(Q&S), HA supplemented that while the experience of the three-year pilot scheme of hospital accreditation was on the whole positive, it did cause additional workload to the frontline, for which HA needed to monitor closely in view of the stringent manpower situation at hand. Besides, it would take time to build up sufficient local surveyor capacity to sustain and expand the hospital accreditation scheme. Taking those into consideration, HA had planned the next phase of the accreditation programme to cover another 15 public hospitals in five to seven years.

Number of sentinel and serious untoward events

9. Ms LI Fung-ying noted with grave concern that the number of sentinel and serious untoward events in public hospitals had not been greatly reduced after the implementation of the Sentinel Event Policy in October 2007 and the revised Sentinel and Serious Untoward Event Policy in January 2010. On the contrary, the number of cases of "retained instruments or other materials after surgery/interventional procedure" had surged from 10 cases for the period of 1 October 2007 to 30 September 2008 to 18 cases for the period of 1 October 2010 to 30 September 2011. She asked whether human error or system factor was the key contributing factor to these medical incidents. She also doubted whether the clinical governance system of HA and the improvement measures put in place to avoid recurrence of medical incidents were merely paperwork.

10. Director(Q&S), HA advised that similar to overseas experience, local medical incidents were mainly caused by system and process factors rather than mere human errors. Improvement could be made to the relevant systems and work procedures to avoid recurrence of similar incidents. For instance, there had been a significant drop in the number of cases of misidentification of patients' specimens after the implementation of the two-dimensional barcoding system

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for blood transfusion and laboratory tests to facilitate patient identification. As regards the cases of "retained instruments or other materials after surgery/interventional procedure", HA noticed the rise in number was related more to small materials (such as tiny broken tips of surgical instruments) rather than a whole instrument. As such, measures effective for preventing the retention of whole instrument and gauze, for example, "time out", might not be applicable to cases involving small materials.

11. Ms LI Fung-ying expressed dissatisfaction with the response of HA. She asked whether the current number of sentinel and serious untoward events was considered acceptable and there was no room for further improvement.

12. Dr PAN Pey-chyou did not subscribe to HA's explanation. He asked whether HA had assessed the effectiveness of the Advanced Incidents Reporting System and the Sentinel Event Policy as their coming into operation in 2004 and 2007 respectively had not reduced the number of sentinel and serious untoward events in public hospitals.

13. DSFH(H)1 responded that there was no room for complacency and continuing efforts would be made to identify risks and implement appropriate measures to reduce the recurrence of similar medical incidents. Director(Q&S), HA supplemented that the number of sentinel and serious untoward events in public hospitals was on par with that of Western Australia. Given the complex healthcare settings, it would be difficult, if not impossible, for hospitals to attain zero medical incidents. Notwithstanding this, HA accorded the highest priority to patient safety and would investigate each sentinel and serious untoward event with a view to identifying the likely causes of the incident and improvement measures. With advancement in technology, such as the barcode technology, further improvements could be made to existing systems and work procedures to reduce the number of medical incidents.

14. Dr PAN Pey-chyou enquired whether there was any international standard classification of sentinel events, and if so, the level of performance of public hospitals in Hong Kong as compared with other developed countries in terms of the ratio of sentinel events to service volume.

15. Director(Q&S), HA responded that there was no international standard classification of sentinel events. The categories and definitions of sentinel events under HA's Sentinel Event Policy was modelled largely on the sentinel event reporting mechanism of Western Australia. While it was difficult to make a direct comparison between local medical incidents statistics with those in other countries because of the differences in the mechanisms and culture of reporting medical incidents, research studies often reported up to 10% of hospital admissions could end up in some form of mishaps, even in developed countries such as the United States and Western Europe.

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16. Dr PAN Pey-chyou was dissatisfied with the response given by HA. While recognizing that it might not be possible to make a direct comparison between local medical incidents statistics with those in other countries, he held the view that HA should at least conduct a comparison on an item-by-item basis with a view to measuring the performance of the public hospitals on each category of the sentinel and serious untoward events.

17. The Chairman expressed similar views, adding that it should be feasible to compare the local occurrence rate of cases of "retained instruments or other materials after surgery/interventional procedure" and "death of an in-patient from suicide (including home leave)", which accounted for more than 80% of the sentinel and serious untoward events in public hospitals, with that of other developed countries.

18. Director (Cluster Services), HA ("Director(CS), HA") advised that in examining the number of sentinel and serious untoward events in public hospitals, it was more important to look at the general trend, rather than the absolute figure, of each category of incidents so as to identify improvement measures to avoid the recurrence of the incident. Dr PAN Pey-chyou requested HA to provide written information on the trend of each category of sentinel and serious untoward events since the implementation of the Advanced Incidents Reporting System in 2004.

HA/ Admin

19. Mr CHAN Kin-por sought explanation for the rebound in the number of cases of "death of an inpatient from suicide (including home leave)" during the period of 1 October 2010 to 30 September 2011.

20. Director(Q&S), HA advised that while measures implemented in the past few years had effectively lower the suicide rate of inpatients with mental illness, it was found that there was an increasing number of inpatients having terminal cancer committing suicide. HA would revisit the suicidal risk of these patients and identify measures to better address their psychological needs.

21. In response to Mr CHAN Kin-por's further enquiry on whether there was any significant difference in the number of medical incidents amongst clusters, Director(Q&S), HA replied in the negative.

Management of medical incidents

22. Noting that the hospital concerned had to report a sentinel or untoward event to the HA Head Office within 24 hours, Mr CHAN Kin-por considered that it should at the same time inform the patient's family members of the details of the incident.

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23. Director(Q&S), HA assured members that after a medical incident was revealed, the healthcare team concerned would immediately explain the incident and offer necessary assistance to the patients and/or their family members. However, there was room for improvement in the communication between the healthcare personnel and the patients and/or their family members, especially when the former needed time to investigate into the incident in order to respond to questions raised by the patients and/or their family members and the latter were still suffering from emotional distress.

24. While commending the service quality of public hospitals, Ms Audrey EU expressed disappointment that the Administration had failed to respond to the repeated call from Members of the Legislative Council ("LegCo") to establish an independent statutory Office of the Health Service Ombudsman to handle medical incidents occurred in public hospitals so as to ensure the independence of investigations and better protect the interest of patients. She asked whether the Administration would study the need for establishing the Office within the current term of Government.

25. DSFH(H)1 pointed out that for public healthcare services, a two-tier complaint system had been put in place by HA to handle complaints lodged by patients. All complaints would be handled and responded to directly by the respective hospitals in the first instance. Complainants who wished to put forward further views or were not satisfied with the handling/outcome of his/her complaint could appeal to HA's Public Complaints Committee, which comprised medical experts and lay members from different sectors of the community, for a review. Under the principle of professional autonomy, the independent statutory bodies which regulated the respective medical and healthcare professions were responsible for handling complaint cases against the professional conduct of their members. Members of the public could also air grievances on public hospital services by lodging complaints to the Office of The Ombudsman. In addition, the Coroner's Court would inquire into deaths of patients which occurred, among others, under suspicious circumstances. Given the well-established complaint redress avenues in Hong Kong, creation of the proposed Office of the Health Service Ombudsman might make the existing system much more cumbersome. DSFH(H)1 further pointed out that the United Kingdom had decided not to pursue with the establishment of an independent medical ombudsman after taking into account the response of the public and the profession towards the relevant pilot scheme.

26. In response to Ms Audrey EU's enquiry on whether the Administration would initiate a public consultation exercise to invite public views on whether the proposal of establishing an independent statutory Office of the Health Service Ombudsman should be pursued, DSFH(H)1 reiterated that the existing mechanisms were effective in handling complaints of medical nature. Ms Audrey EU expressed regret to the Administration's response.

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27. Mr Andrew CHENG opined that the existing mechanism adopted by public hospitals was unable to ensure a fair and impartial investigation into a medical incident as the investigation would be conducted by the hospital concerned for submission to the HA Head Office. Pointing out that the establishment of an Ombudsman Office for handling healthcare complaints was first recommended in the Harvard Report published in April 1999 and motions calling for the creation of an Office of the Health Service Ombudsman had been repeatedly carried at meetings of LegCo, he expressed regret that the Administration did not take heed of the suggestion.

Support to staff involved with medical incidents

28. Dr Joseph LEE expressed disappointment that the Administration's paper did not mention how HA would, apart from promulgating various protocols to provide guidance to clinical staff, assist its management and frontline personnel in the handling of medical incidents to avoid recurrence of the incidents.

29. Director(Q&S), HA reiterated that medical incidents were mainly caused by system and process factors rather than human errors. To prevent or minimize medical incidents from occurring in public hospitals, HA had put in place system safeguards and risk management initiatives by making use of information technology to ensure safer practices and reduce unintended human errors in healthcare setting. HA would also provide emotional support to staff involved with the incidents.

Healthcare manpower needs

30. Mr CHAN Hak-kan urged the Administration to look squarely at the problem of insufficient healthcare manpower of public hospitals which, in his view, was an underlying factor contributing to the occurrence of medical incidents.

31. DSFH(H)1 responded that additional resources had been and would continue to be allocated to HA to strengthen its manpower of doctors and nurses. In addition, a high-level steering committee would be set up under the Food and Health Bureau to conduct a strategic review on healthcare manpower planning and professional development.

32. Mr CHEUNG Man-kwong said that the crux of the problem leading to the frequent occurrence of medical incidents at the Tuen Mun Hospital ("TMH") in the past few months lay in the insufficient healthcare manpower. While local specialist doctors could not be made available overnight, the registration of non-local medical graduates to practise in Hong Kong was subject to various requirements. Given an increasing number of experienced doctors leaving the employ of HA to enter the expanding private sector or the Mainland market

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through leveraging on the opportunities made available by the Mainland and Hong Kong Closer Economic Partnership Arrangement, he asked how HA could assure the quality of the public healthcare services.

33. Director(CS), HA admitted that there was an acute shortage of doctors in public hospitals due to the drastic drop in the yearly supply of local medical graduates from 310 in 2007-2008 and 2008-2009 to 280 in 2009-2010 and 2010-2011, and further to 250 in 2011-2012. It was anticipated that manpower of doctors would remain tight in the next few years until 2015-2016 when there would be an increase in the number of local medical graduates to 320 per year and further to 420 in 2018-2019. HA had implemented a series of measures, including, among others, enhancement of remuneration package, improvement of working conditions and enhancement of promotion prospects and training opportunities, in the past few years to retain the medical workforce. Following the implementation of a basket of measures, the overall turnover rate of doctors had dropped from 6.6% in 2006-2007 to 5.3% in 2010-2011. With a view to strengthening the doctor manpower in the short run, HA had allowed greater flexibility for employment of part-time doctors and recruited non-local doctors to practise with limited registration. At present, there were around 170 local doctors serving in the public hospitals on a part-time basis. On 4 January 2012, the Medical Council of Hong Kong had also approved the first batch of applications of nine non-local doctors for limited registration to serve in public hospitals. HA would submit the second batch of applications to the Medical Council of Hong Kong in the next three months. As regards nursing manpower, it was anticipated that the substantial increase in the supply of nursing graduates to more than 2 000 each year in the next few years could relieve the pressure of nursing manpower shortage.

34. Director(CS), HA further pointed out that there was not much difference between the New Territories West cluster ("NTWC") where TMH was located and other clusters in the number of medical incidents. Cluster Chief Executive, New Territories West Cluster/Hospital Chief Executive, Tuen Mun Hospital, HA ("CCE/HCE") supplemented that the management and frontline staff of TMH were deeply concerned about and saddened by the recent medical incidents. The Cluster Clinical Governance Committee of NTWC had reviewed the situation with a view to identifying measures to reduce risk and enhance service quality so as to regain patients' trust and public confidence. On the healthcare manpower of NTWC, CCE/HCE advised that about 500 additional beds were opened in NTWC in the past five years to cope with the growing service demand. The expansion of the service capacity, together with the high turnover of doctors and nurses in 2010-2011, had created tremendous work pressure on the healthcare personnel of NTWC, albeit that additional healthcare manpower had already been provided and there were 29 doctors serving NTWC on a part-time basis. The cluster was presently in discussion with the HA Head Office on the allocation of new resident trainees

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in July 2012 to cater for further expansion of services and relieve the heavy workload of the current slim workforce. It was anticipated that the supply of around 100 nurse graduates from the nursing school at TMH, which was re-opened in 2009, from 2011 onwards, coupled with the annual allocation of new nurse recruits, would gradually strengthen the nursing workforce. In addition, some 70 Technical Services Assistants and more than 20 phlebotomists, as well as a number of clerical staff, had been employed recently to take up the technical or non-clinical duties so as to relieve the workload of frontline doctors and nurses of NTWC.

35. Dr Joseph LEE was concerned that the taking up of the technical duties by the Technical Services Assistants and phlebotomists would undermine the competency of junior doctors and nurses in performing these duties as and when necessary.

36. Director (CS), HA assured members that there was no cause of such concern as doctors and nurses would also have opportunities to perform these technical duties. The arrangement would however ensure that doctors and nurses could devote more work hours to other professional and clinical duties.

37. Mr CHEUNG Man-kwong sought information on the anticipated yearly shortfall of doctors in public hospitals from 2016 to 2019 and the measures to be put in place by HA to address the anticipated shortfall.

38. Director(CS), HA responded that there was presently a shortfall of around 200 doctors in public hospitals. In addition, the anticipated replacement demand generated by turnover would be about 250 doctors each year. However, the number of doctors available for recruitment would remain at 300 to 320 each year (i.e. 250 local medical graduates, some 20 overseas medical graduates who had passed the Licensing Examination of the Medical Council of Hong Kong and some 30 existing qualified doctors in the market). In the light of this, the problem of shortfall of doctors in public hospitals would persist in the next few years. Under such circumstances, the employment of part-time doctors and non-local doctors with limited registration was necessary to strengthen the medical workforce at the short run.

39. Pointing out that the medical workforce in public hospitals had increased significantly by 40% when compared with that of 14 years ago, the Chairman sought the reasons for the present medical manpower shortage problem when figures provided by HA, such as the average number of hospital bed days and the number of Accident and Emergency attendances, suggested a decline in service demand in the last decade.

40. Director(CS), HA explained that medical manpower projection was a complex process as there were many intertwining and unpredictable factors at

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play. With advancement in medical technology, treatment and procedures had become increasingly sophisticated which entailed additional healthcare manpower resources. The growth and ageing of population had also led to rapid increase in demand for healthcare services and treatment with higher level of complexity. The healthcare service demand would also be affected by the factor of economic conditions. When the economy was good, there would be an increase in healthcare services demand. In economic downturn, there would be a decrease in the number of people seeking private healthcare services. In projecting the medical manpower requirement, there was the additional need to take into account the long lead time for specialist training of doctors, i.e. six years of undergraduate training plus a minimum of another six years of post-registration specialist training.

41. Director(CS), HA further said that while there was a persistent increase in the total number of patient discharges, an increasing number of patients were undergoing day surgeries and receiving day hospital services. Hence, there was a reduction in the average length of stay for inpatients. Director(CS), HA however stressed that neither the number of patient discharges nor the average number of bed days could accurately reflect the service volume of public hospitals as no account had been taken of the additional activities carried out by doctors in taking care of each patient due to the increasingly sophisticated treatment and procedures.

42. The Chairman urged HA to explore the use of other indicators to accurately reflect the rise in public healthcare service volume. Director(CS), HA agreed, adding that case mix, which enabled the generation of information on the level of complexity of the treatment for each patient, could be an option for consideration.

43. Holding the view that the knowledge and skills of the leaving experienced doctors could not be replaced by new recruits who were mostly fresh medical graduates, Mr Alan LEONG expressed grave concern about the service quality of the public healthcare system when there was already a shortfall of around 200 doctors. Dr Joseph LEE expressed a similar concern.

44. Director(CS), HA advised that to ensure staff's professional competence, HA had all long attached great importance to training and development of its doctors and would continue to enhance the opportunities for specialist doctors to attend overseas training or attachment. In addition, measures had been and would continue to be taken by HA to retain its medical talents. HA would also invite retired specialist doctors to work on a part-time basis.

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V. Commencement of Undesirable Medical Advertisements (Amendment) Ordinance
(LC Paper Nos. CB(2)712/11-12(05) and (06))

45. DSFH(H)1 briefed members on the Administration's plan to commence the provisions in the Undesirable Medical Advertisements (Amendment) Ordinance 2005 ("the Amendment Ordinance") related to the control of health claims of orally consumed products on 1 June 2012, details of which were set out in the Administration's paper (LC Paper No. CB(2)712/11-12(05)). Principal Medical & Health Officer(5), Department of Health highlighted the publicity activities launched by the Department of Health ("DH") to help the trade better understand the new provisions under the Amendment Ordinance.

Allowable claims and disclaimer

46. Mr Fred LI said that he welcomed the legislative proposal as the commencement of the Amendment Ordinance had been long awaited. He noted from the Administration's paper that four specific claims were allowed for health claims relating to regulation of body sugar or glucose, regulation of blood pressure and regulation of blood lipids or cholesterol in a new Schedule 4 to the Undesirable Medical Advertisements Ordinance (Cap. 231) ("the Ordinance"). However, for products not registered under the Pharmacy and Poisons Ordinance (Cap. 138) ("PPO") and the Chinese Medicine Ordinance (Cap. 549) ("CMO"), a mandatory disclaimer must be clearly put in the advertisement to inform consumers that the orally consumed products were not products registered under PPO or CMO. Mr LI sought clarification as to whether the Chinese rendition of the term "disclaimer" used in the Amendment Ordinance was "免責聲明" or "卸責聲明" as used in the Administration's paper for this term.

47. DSFH(H)1 advised that the Chinese legal term for "disclaimer" was "卸責聲明". The purpose of requiring a disclaimer to be put in the advertisement was to state clearly that the orally consumed products were not medicines registered under PPO or CMO which would enable consumers to make an informed decision.

48. Mr Fred LI was concerned that the font size of the health claims or disclaimers in the advertisements was always too small to be easily readable and could not serve the purpose of safeguarding public health. DSFH(H)1 responded that given the wide variations in the size of the packaging of products, there was practical difficulty in specifying the requirements on the font size of the words printed on the disclaimer. Although the Amendment Ordinance did not provide for any specifications on the font size of health claims or disclaimers, it required that products not registered under PPO or

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CMO must clearly carry a disclaimer in the advertisement to inform consumers that they were not products registered under the two Ordinances when the specified permissible claims were made.

49. Dr PAN Pey-chyou pointed out that there was a free flow of information on the internet and information on medicines or food products making health claims could be easily accessible. He questioned the effectiveness of prohibition/restriction on advertising to certain health claims as specified in the Amendment Ordinance. He was of the view that advertisements making untruthful health claims should be prohibited, rather than restricting advertisements making specific health claims.

50. DSFH(H)1 responded that under the Amendment Ordinance, prohibition/restriction was imposed on the advertising of certain health claims of orally consumed products. For those orally consumed products which were not registered under PPO or CMO, a disclaimer must also be added to indicate so when the specified permissible claims were made in the advertisements. The aim was to protect the general public from being induced by the advertisements (such as in the form of label and poster) into seeking improper self-treatment with these products, thereby causing a delay in the proper management of their conditions.

Regulation of health food products

51. Mr Fred LI raised great concern about the regulation of health food products making misleading or exaggerated claims relating to slimming/fat reduction. He was disappointed that the claims made by health food products relating to slimming/fat reduction were not subject to the regulation of the Amendment Ordinance.

52. DSFH(H)1 explained that the purpose of the Ordinance was to protect the general public from being induced by advertisements to seek improper self-medication or treatment of diseases instead of consulting relevant healthcare professionals. The new Schedule 4 adopted a risk-based approach in the prohibition/restriction on advertising to six additional groups of claims specified in the Schedule. Taking into account that the risk of delayed proper treatment of diseases due to orally consumed products with claims relating to slimming/fat reduction was considered relatively low, such claims were not included under the purview of the Amendment Ordinance.

53. Echoing Mr Fred LI's concern, Dr Joseph LEE doubted how the Administration could safeguard the safety of the general public in the absence of regulation on health food products in Hong Kong. He asked whether the Administration would consider enacting legislation to regulate health food products.

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54. DSFH(H)1 reiterated that the Amendment Ordinance adopted the risk-based approach and restricted the more risky claims as set out in Schedule 4 to prevent the general public from seeking improper self-medication or treatment. Effectiveness of health foods in achieving their claims did not fall within the scope and object of the Amendment Ordinance. Whether health food could achieve its beneficial health effects was a matter of consumer interest, which was regulated by other ordinances. For instance, the nutrition labelling and claims of general food products were required to comply with the statutory nutrition labelling requirements, and false trade descriptions in respect of goods were regulated by the Trade Descriptions Ordinance (Cap. 362).

55. On the Administration's response, Dr Joseph LEE commented that effectiveness of health foods in achieving their claims was not merely a matter of protection of consumer interests but also an issue concerning the safeguarding of public health.

56. While welcoming the commencement of the Amendment Ordinance, Mr IP Kwok-him raised concern about the sale activities of health related products in temporary vacant shop premises and whether verbal presentation of advertisements of products with beneficial health claims was subject to regulation.

57. Deputy Director of Health, Department of Health ("DDH") responded that cases suspected to have contravened the Ordinance would be investigated to determine whether the specific requirements have been breached. After the implementation of the Amendment Ordinance, there would be 23 conditions under which advertising would be restricted/prohibited.

58. In response to the concern raised by Mr IP Kwok-him on the impact brought about by the Amendment Ordinance on the proprietary Chinese medicine ("pCm") trade, DDH explained that sections 1, 9 and 11 of the Amendment Ordinance had come into operation in January 2006. As the remaining provisions under the Amendment Ordinance provided that orally consumed products carrying certain health claims but not registered under PPO or CMO must carry a disclaimer, they could only be brought into operation after commencement of the mandatory registration and the requirements of label and package insert of pCm under CMO. Considering that the mandatory registration and the requirements of label and package insert of pCm under CMO had been fully implemented in December 2011, the Administration proposed to commence the remaining provisions under the Amendment Ordinance on 1 June 2012. DDH further advised that to help the trade better understand the new provisions under the Amendment Ordinance, DH had launched two rounds of publicity activities to the relevant traders, including traders of pCM, in 2006 and 2011. The pCm trade did not indicate that it would have any difficulties in complying with the provisions of the Amendment

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Ordinance. The Administration would continue to keep the pCm trade informed and welcomed the trade to contact DH for enquiries about the new regulations under the Amendment Ordinance.

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

Regulation of infant formula advertisements

60. Ms Audrey EU raised concern about the control of infant formula advertisements as the claims in some infant formulas were exaggerating and misleading. She enquired whether the Administration had any legislative plan to regulate misleading or exaggerated claims in the advertisements of infant formula. Ms EU said that given that a long lead time would be required for enacting a new piece of legislation, she urged the Administration to expedite the introduction of the legislation regulating infant formula advertisements making misleading or exaggerated health claims.

61. DDH responded that the Ordinance might not be an appropriate legal instrument to regulate the claims in the advertisements of infant formula. The Food and Health Bureau was aware of the concerns that the claims in some infant formulas might be exaggerating and misleading and the calls for control in this respect. She would relay members' concerns and views to the colleagues responsible for food safety in the Food and Health Bureau for consideration.

VI. Any other business

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

Council Business Division 2
Legislative Council Secretariat
6 March 2012