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Legislative Council

LC Paper No. CB(2)2817/11-12
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Panel on Health Services

Minutes of meeting
held on Tuesday, 10 July 2012, from 8:30 am to 11:00 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 LI Fung-ying, SBS, JP Hon Audrey EU Yuet-mee, SC, 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 IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou Dr Hon Samson TAM Wai-ho, JP Hon Alan LEONG Kah-kit, SC
Member attending	:	Hon WONG Kwok-hing, MH
Members absent	:	Hon Andrew CHENG Kar-foo Hon Vincent FANG Kang, SBS, JP Hon CHEUNG Hok-ming, GBS, JP Hon CHEUNG Kwok-che

Public Officers attending	:	Items II to V Dr KO Wing-man, BBS, JP Secretary for Food and Health Mr Richard YUEN Ming-fai, JP Permanent Secretary for Food and Health (Health) Items II, IV and V Dr CHEUNG Wai-lun Director (Cluster Services) Hospital Authority Item II Ms Ivis CHUNG Chief Manager (Allied Health) Hospital Authority Items III and V Mr Chris SUN Yuk-han, JP Head, Healthcare Planning and Development Office Food and Health Bureau Item III Dr LIU Hing-wing Director (Quality & Safety) Hospital Authority Dr Alexander CHIU Chief Manager (Quality & Standards) Hospital Authority Item IV Ms Linda WOO Chief Pharmacist (1) Department of Health

Ms Teresa NGAN
Senior Pharmacist
(Special Services & Chinese Medicines)
Hospital Authority

Item V

Dr Cindy LAI Kit-lim, JP
Deputy Director of Health

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

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

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

Dr Lisanne KO
Research Officer (2) 1

Ms Priscilla LAU
Council Secretary (2) 5

Ms Sandy HAU
Legislative Assistant (2) 5

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

Members noted that no information paper had been issued since the last meeting.

II. Regularization of Community Care Fund Medical Assistance Programme Second Phase

[LC Paper Nos. CB(2)2526/11-12(01) and (02)]

2. The Chairman welcomed the Secretary for Food and Health ("SFH") and other representatives of the Administration to the meeting.

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3. SFH and Director (Cluster Services), Hospital Authority ("Director (CS), HA") briefed members on a proposal by the Hospital Authority ("HA") to incorporate the Community Care Fund ("CCF") Medical Assistance Programme Second Phase ("CCF Medical Second Phase Programme") into the Samarian Fund ("SF"), details of which were set out in the Administration's paper (LC Paper No. CB(2)2526/11-12(01)).

Regularization of CCF Medical Second Phase Programme

4. Noting that the CCF Medical Second Phase Programme aimed to provide additional subsidy to needy patients by reducing their maximum contribution ratio on drug costs from 30% to 20% of their household annual disposable financial resources, the Chairman sought information on the source of funding for the proposed regularization of the CCF Medical Second Phase Programme.

5. SFH advised that upon incorporation of the CCF Medical Second Phase Programme into SF on 1 September 2012, the subsidy in respect of the reduction in patients' contribution on the designated SF drugs currently provided under the CCF Medical Second Phase Programme would be covered by SF.

6. While welcoming the proposed regularization of the CCF Medical Second Phase Programme, Mr IP Kwok-him noted with concern that the number of approved applications under the CCF Medical Second Phase Programme was only 197 as at the end of May 2012. He sought information about the number of patients who would benefit from the regularization proposal.

7. Director (CS), HA advised that the proposed regularization of the CCF Medical Second Phase Programme was in line with the direction of further relaxing the financial assessment criteria for drug subsidies under SF and would benefit more patients. It would be implemented concurrently with two other measures proposed by HA to relax the financial assessment criteria of SF in September 2012. These two measures were the introduction of a deductible allowance for calculating disposal capital and the simplification of the tiers of patients' contribution ratio. It was estimated that about 2 300 patients would be benefited from the implementation of these two measures. The total number of beneficiaries of the proposed regularization of the CCF Medical Second Phase Programme and the measures to relax the SF assessment criteria would be around 3 000. Coupled with the expansion of the Drug Formulary of HA, it was expected that the number of patients benefited from the proposed regularization would be even larger.

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8. Noting that the CCF Medical Second Phase Programme had approved 197 applications for a grant of $4.73 million after four months of implementation, Dr PAN Pey-chyou expressed concern about the financial impact on SF after the regularization of the CCF Medical Second Phase Programme. SFH advised that the healthcare professionals and patients groups were well aware of the financial assistance provided to the needy patients through SF and CCF. In his view, the applications for financial assistance would only slightly increase after incorporating the CCF Medical Second Phase Programme into SF.

Self-financed drugs covered by the Samaritan Fund

9. Ms Audrey EU was of the view that there would not be a significant increase in the number of beneficiaries after the regularization of the CCF Medical Second Phase Programme. Pointing out that SF had received a Government grant of $10 billion, Ms EU urged the Administration to expand the scope of the safety net of SF to cover more self-financed drugs, such as cancer drugs, Imatinib and drugs for treating Thalassaemia. Dr PAN Pey-chyou also called on the Administration to expand the safety net of SF.

10. SFH advised that under the existing mechanism, the HA Drug Utilization Review Committee would advise on the potential list of self-financed drugs to be supported by SF, having regard to the scientific and clinical evidence on the safety, efficacy and cost-effectiveness of the drugs. Apart from SF, the CCF Medical Assistance Programme First Phase would provide financial assistance to needy HA patients for the use of specified self-financed cancer drugs which had not been brought into the safety net of SF but had been rapidly accumulating medical scientific evidence and with relatively high efficacy. SFH assured members that HA would continue to review the safety net of SF on a regular basis and include those self-financed drugs which met the scientific and clinical requirements into the safety net of SF.

11. The Chairman considered the current mechanism unfair to the middle class families who did not meet the eligibility criteria for SF and were required to purchase costly self-financed drugs at their own expense. In his view, under the principle of equity, HA should provide adequate healthcare services for all people, regardless of their financial capability. He urged the Administration to review the mechanism and operation of the Drug Formulary and SF, and revert to the Panel on the outcome of the review in the next legislative term.

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12. While agreeing that there was room for improvement in the Drug Formulary and SF, SFH stressed that with limited resources, it would be prudent for HA to rationally target the finite public resources to support treatment of proven effectiveness to patients, and provide financial subsidy to assist needy patients.

III. Implementation of hospital accreditation in public hospitals

[LC Paper Nos. CB(2)2526/11-12(03) and (04)]

13. SFH briefed members on the progress of the implementation of hospital accreditation in public hospitals by HA, details of which were set out in the Administration's paper (LC Paper No. CB(2)2526/11-12(03)).

Implementation of hospital accreditation

14. Dr Joseph LEE pointed out that the implementation of the Pilot Scheme on Hospital Accreditation ("Pilot Scheme") at five major public hospitals had further strained the manpower resources of public hospitals and increased patients' expectation for higher quality care. Noting that the Phase II Hospital Accreditation Programme ("Phase II Programme") would be implemented in 15 public hospitals, half of which would be small public hospitals, Dr LEE enquired how the Administration could ensure a smooth implementation of the Phase II Programme.

15. Given the manpower constraint of public hospitals, Ms LI Fung-ying expressed grave concern that the implementation of the Phase II Programme would further increase the workload and pressure of the frontline staff. She sought information on the measures to resolve the difficulties experienced by the frontline staff when carrying out the Pilot Scheme under the Phase II Programme. Ms Audrey EU sought details on the improvement in the quality of patient care with the implementation of the Phase II Programme.

16. SFH advised that to address the medical and nursing staff's concern on the additional workload under the Phase II Programme, HA had extended the implementation period of the Phase II Programme from five to seven years. HA would also review the various quality assurance programmes currently run by public hospitals with a view to avoiding unnecessary overlap and reducing duplication of efforts. As regards patients' expectation, SFH advised that HA attached great importance to communicate with patient groups that hospital accreditation primarily focused on enhancing patient safety.

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17. Director (Quality & Safety), HA supplemented that hospital accreditation was a process for continuous improvement. The organization-wide accreditation surveys would identify areas which required improvement. For instance, HA had allocated $100 million to improve the ventilation system and sterilization practices in the operating theatres of public hospitals in the course of preparing public hospitals for accreditation, resulting in enhanced safety for patients and healthcare staff.

Local accreditation standards

18. Noting that a set of locally applicable standards, namely the fourth edition of Evaluation and Quality Improvement Programme Hong Kong Guide, had been developed for measuring the performance of public and private hospitals in Hong Kong, Ms Audrey EU enquired whether the local standards were on a par with the international standards.

19. SFH advised that the partnering with an internationally recognized accreditation body, namely the Australia Council on Healthcare Standards, ensured that the hospital accreditation scheme was up to international standards. To give due consideration to the local context, the locally adapted accreditation standards were developed based on international standards. The local accreditation standards were also subject to regular reviews and updates in accordance with international practice. SFH further advised that the training and continued development of a local pool of surveyors were equally important for the implementation of hospital accreditation. In this regard, an additional of about 60 surveyors would be trained and appointed as local surveyors under the Phase II Programme.

Assessment of effectiveness of hospital accreditation

20. Pointing out the substantial non-clinical workload generated from the implementation of the Pilot Scheme, Dr PAN Pey-chyou considered that the implementation of the Phase II Programme would be well justified if it could be demonstrated conclusively that substantial benefits would be achieved over the additional workload generated. He sought details on the improvement in the quality of patient care and patients' satisfaction at the five major hospitals which had been awarded full accreditation status under the Pilot Scheme.

21. SFH advised that the Pilot Scheme was introduced to benchmark the healthcare services of public hospitals against international standards. Through the accreditation process, namely, adoption of internationally recognized standards, training and education and independent accreditation surveys, participating public hospitals could demonstrate their compliance

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with international standards and continuously strive towards service improvement through changes in systems and practices where appropriate. SFH further advised that hospital accreditation would review the practices of the participating hospitals but would not directly assess improvement in areas of patient care or patient safety through indicators such as the number of sentinel events. That said, HA had put in place a mechanism for quality assurance and risk monitoring, and such mechanism would be a useful tool for assessing the performance of public hospitals in these areas after the hospitals had been awarded the full accreditation status.

22. Ms Audrey EU and Ms LI Fung-ying cast doubt on whether hospital accreditation could improve service quality of public hospitals and enhance patient safety as there were no objective indicators for measuring the performance of hospitals in this regard. SFH stressed that although indicators to measure service quality and sentinel events were not readily available under the hospital accreditation scheme, the scheme would assess the observance of good clinical practice in the participating hospitals. HA had put in place a risk management mechanism as well as laid down requirements for safeguarding patient safety and ensuring service quality. Furthermore, HA had deployed resources to improve hospitals' underperformed areas identified in the Pilot Scheme.

23. Ms LI Fung-ying maintained the view that objective indicators such as the number of sentinel events were important for assessing the quality of patient care delivered by the public hospitals. The Chairman concurred with Ms LI's view and called on the Administration to formulate a set of objective indicators to measure the effectiveness of hospital accreditation implemented at public hospitals.

IV. The "approved person" system adopted by the Hospital Authority for the dispensaries of its General Outpatient Clinics

[LC Paper Nos. CB(2)2526/11-12(05) and (06)]

24. SFH and Director (CS), HA briefed members on the "Approved Person" arrangement adopted by HA for the pharmacies of its General Outpatient Clinics ("GOPCs"), details of which were set out in the Administration's paper (LC Paper No. CB(2)2526/11-12(05)).

25. Dr PAN Pey-chyou said that he requested the discussion of this issue on behalf of the Hong Kong Government Pharmaceutical Dispenser Association ("HKGPDA"). Dr PAN pointed out that while the "Approved Person" arrangement was an established practice adopted from the Department of Health ("DH") when HA took over the 59 GOPCs from DH

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in July 2003, the volume and complexity of the work of GOPC pharmacies under the management of HA had drastically increased with the implementation of the arrangement for patient referral from Specialist Outpatient Clinics to GOPCs for follow-up consultation and collection of drugs. Given that some "Approved Persons" had raised grave concern about the unclear scope of their responsibilities, he demanded sight of the appointment certificate of the "Approved Person".

26. Director (CS), HA agreed that the operation of GOPC pharmacies had become more comprehensive. He assured members that HA would keep in view the operational needs of GOPC pharmacies, including, among others, the workload of senior dispensers and dispensers. To strengthen the pharmacist support and enhance the overall efficiency of pharmaceutical services in GOPCs, HA had strengthened the manpower of pharmacist from zero to 71 persons over the years. In tandem, the Director of Health ("DoH") had approved the extension of the "Approved Person" arrangement for GOPCs in 2006, 2009 and 2012. Since 2009, HA had issued written notice to the staff concerned on DoH's approval for extending their "Approved Person" status in GOPCs. It should be noted that in accordance with the Dangerous Drugs Ordinance (Cap. 134) ("the Ordinance") and the Pharmacy and Poisons Regulations (Cap. 138A) ("the Regulations"), the "Approved Person" would perform the duties of possession and supply of dangerous drugs as well as supervising the dispensing of poisons in the absence of on-site pharmacists and when there was a service need. The duties of "Approved Person" were part of the daily and professional duties of the dispenser grade staff. The work arrangement was also consistent with that when they worked in GOPC pharmacies under DH's management in the past. At the request of Dr PAN Pey-chyou, Director (CS), HA undertook to provide the "Approved Persons" with the relevant information on their scope of responsibilities.

HA

27. Dr PAN Pey-chyou pointed out that HKGPDA had reflected to him that the increase in the manpower of pharmacists in HA had helped little in supporting the operation of the pharmacies of GOPCs. He asked whether a large proportion of the increased manpower had been deployed to support the public hospital pharmacies in view of the increasing number of dispensing incidents in recent years, and hence requiring more pharmacists to monitor the dispensing procedures so as to minimize any risk of errors. Director (CS), HA clarified that the number of pharmacists referred to in paragraph 26 above was referring to those deployed by HA to be in charge of GOPC pharmacies and be responsible for the management of their daily operation. HA would keep under review the adequacy of the professional services provided by pharmacists to GOPC pharmacies.

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28. Pointing out that it was unfair to require the "Approved Person" to perform part of the professional duties of the pharmacist as the entry requirements and remuneration of the pharmacist and dispenser grades were different, Ms LI Fung-ying was concerned that such arrangement was by no means unique to these two grades but was common across all healthcare-related grades. A case in point was the undertaking of the nurse's personal care duties by the health care assistant. She urged HA to rationalize the demarcation of roles and responsibilities between the pharmacist and dispenser grades, as well as other healthcare-related grades, to ensure that the quality of healthcare services would not be undermined.

29. SFH said that there was no question of HA intending to replace pharmacists by dispensers through the adoption of the "Approved Person" arrangement for its GOPC pharmacies. Before HA took over GOPCs from DH in July 2003, senior dispensers and dispensers had all long been in charge of GOPC pharmacies and were responsible for possessing and supplying dangerous drugs and supervising the dispensing of poisons. With the enhancement of manpower of pharmacists by HA over the years, the "Approved Persons" were no longer required to be in charge of GOPC pharmacies. The number of "Approved Person" had also gradually decreased from 93 senior dispensers and dispensers in 2003 to 34 senior dispensers in July 2012. The Administration would work with HA to help relieve the work pressure faced by the healthcare personnel working in HA, including the senior dispensers and dispensers. As regards the employment of health care assistants, SFH pointed out that it was agreed by the nursing sector that personal care duties could be separated from the professional nursing duties for taking up by the health care assistants, so as to strengthen nursing support to patients.

30. Dr Joseph LEE said that he did not subscribe to the Administration's view that there was a consensus in the nursing sector that personal care, which was part of whole person care, should be taken up by the health care assistants. Given that the monthly salary of health care assistants could be less than half of that of nurses, he surmised that the reason for HA to introduce the health care assistant grade in the early years was to lower the staff cost. To strengthen nursing support to patients, HA should set a nurse-to-patient ratio which he had long called for.

31. SFH responded that while there might not be a consensus in the nursing sector on the employment of health care assistants to take up some simple care duties, such an arrangement had helped alleviate the work pressure and workload of nurses given the manpower constraint. That said, the Administration could gauge the views of the sector on the arrangement.

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32. The Chairman asked whether DoH had approved any person to possess and supply dangerous drugs and to supervise the dispensing of poisons at pharmacies of private hospitals and their outpatient clinics in accordance with the Ordinance and the Regulations.

33. SFH replied in the negative, pointing out that the continuous adoption of the "Approved Person" arrangement by HA after taking over GOPCs from DH was due to historical reasons. The implementation of such arrangement was also confined to pharmacies of its GOPCs but not that of the public hospitals. It should also be noted that it was not until recent years that hospital-affiliated satellite outpatient clinics were opened in the private sector. However, the scale of these outpatient clinics and GOPCs was distinctly different.

34. The Chairman enquired whether HA had any plan to scrap the "Approved Person" arrangement in the future if its continuation was merely due to historical reasons. Mr CHEUNG Man-kwong sought clarification on whether the adoption of the "Approved Person" arrangement was based on operational or historical reasons.

35. SFH advised that over the years, HA had been moving towards the direction of reducing the number of "Approved Persons". Director (CS), HA supplemented that the Ordinance and the Regulations required that pharmacies of hospitals and outpatient clinics had to have a registered pharmacist or an "Approved Person" to possess and supply dangerous drugs and to supervise the dispensing of poisons. While a significant majority of the 59 GOPCs were deployed with on-site pharmacists, there was still a need to maintain the "Approved Person" arrangement in the near future, with a view to ensuring that the dispensing services of GOPC pharmacies would not be affected due to the absence of on-site pharmacists.

36. The Chairman, however, opined that the adoption of the "Approved Person" arrangement was due to limited manpower resources of HA. Mr CHEUNG Man-kwong was of the view that the continuation of the "Approved Person" arrangement for building up a pool of dispenser grade staff to perform part of the professional duties of pharmacists when necessary was putting patients at risk. He held the view that for the sake of patient safety, in the long run the control of the storage, supply and dispensing of dangerous drugs and poisons at pharmacies should be handled by professionals possessing the relevant qualification.

37. While acknowledging that services of GOPC pharmacies could be further enhanced, SFH stressed that it was lawful for both the "Approved Person" and the pharmacist to possess and supply dangerous drugs and to

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supervise the dispensing of poisons. The appointment of "Approved Person" was not an arrangement in view of the unavailability of sufficient pharmacists. Given the current small number of "Approved Persons", he could not see why HA could not, in the long run, handle the arrangement as a historical issue. Director (CS), HA reiterated that the pharmacist grade staff could not be replaced by the dispenser grade staff, or vice versa. Senior dispensers of HA had the professional qualification and knowledge and were competent to perform dispensing-related duties in GOPC pharmacies. HA would continue to arrange both pharmacists and dispensers to work together in the GOPC pharmacies so as to meet service needs.

HA/Admin

38. The Chairman requested the Administration and HA to explain clearly to the dispenser grade staff the direction of manpower planning and deployment for GOPC pharmacies. Mr CHEUNG Man-kwong considered that HA should provide on-the-job training to the existing senior dispensers to assist them in obtaining the professional qualification of pharmacist. SFH advised that all dispenser grade staff working in HA pharmacies would receive a variety of continuous professional development training every year, covering pharmacy practice, drug knowledge as well as personal and career development to cope with service needs.

39. Dr PAN Pey-chyou noted with concern the continuous reduction in the number of the post of senior dispenser in HA in recent years. In addition, the lack of promotion opportunity for meritorious dispensers to gain promotion to the senior dispenser level had affected the morale of dispensers. Director (CS), HA responded that the senior dispensers of HA were instrumental in the efficiency of GOPC pharmacies. HA would keep in view the service development and operational needs of GOPCs and deploy its manpower flexibly and determine the appropriate staff mix in order to deliver quality and safe pharmaceutical services to meet patients' needs.

V. Closure arrangement of private hospitals

[LC Paper Nos. CB(2)2526/11-12(07) and FS31/11-12]

40. SFH briefed members on the arrangements to ensure a smooth winding up of the Hong Kong Central Hospital ("HKCH") following a decision by management of the hospital to close its operation, details of which were set out in the Administration's paper (LC Paper No. CB(2)2526/11-12(07)).

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The winding up of HKCH

41. Pointing out that Hong Kong Sheng Kung Hui ("HKSKH"), the landlord of the premises where HKCH was situated, had decided to terminate the tenancy agreement with the Hospital some two years ago, Dr Joseph LEE expressed surprise that DH had not planned ahead to ensure a smooth winding up of HKCH, albeit the judgement by the Court of First Instance on the case had just been handed down on 12 June 2012.

42. SFH advised that the Food and Health Bureau and DH had all long been following up the case. In view of the ruling of the Court of First Instance that HKCH had to close down in three months, DH had instructed HKCH to submit to the Department a detailed plan on closing down its services within one week of the judgement so as to safeguard patients' interests and ensure compliance with relevant legal requirements. DH would closely monitor the service provision and closure arrangements of HKCH.

43. In response to Dr Joseph LEE's further enquiry about whether there were any other private hospitals operating at rented premises, SFH replied in the negative.

Provision of treatment for termination of pregnancy

44. Ms Audrey EU noted that HKCH, which performed 5 800 cases of termination of pregnancy in 2011 (i.e. around 49% of all termination of pregnancy cases in Hong Kong), had been a major provider of the service. In the light of this, she urged the Administration to actively liaise with relevant institutions to ensure that sufficient capacity with reasonable service charge was available to meet the legitimate demand for termination of pregnancy following the closure of the hospital. The Chairman urged the Administration to ensure that there would be sufficient provision of termination of pregnancy services at the private sector in the long run.

45. SFH responded as follows -

(a) the Administration had been liaising with the Family Planning Association of Hong Kong to explore the feasibility of enhancing its capacity so that it could take on more cases of termination of early pregnancy (mostly those less than nine weeks into their pregnancy) that did not require hospital care;

(b) needs for termination of pregnancy in the hospital setting would be met by hospitals approved to provide treatment for

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termination of pregnancy, which included 18 public hospitals and five private hospitals. It should however be noted that DH had no statutory power to regulate the level of charges of private hospitals; and

(c) at present, public hospitals performed less than 2 000 cases of termination of pregnancy each year. Given the uncertainty on the uptake situation in the private sector in respect of the legitimate demands for termination of pregnancy services after the closure of HKCH and the already very heavy workload of the gynaecology and obstetric departments of public hospitals, it was difficult to conclude at this stage whether or not the public hospitals had adequate capacity to meet the service demand in the future. That said, the relevant public hospitals would ensure a smooth operation of the referral arrangement between doctors and the hospitals and make suitable adjustment to their service priority as and when necessary.

46. The Chairman opined that for privacy reason, most women in need of lawful termination of pregnancy would prefer to receive treatment at private hospitals. Noting that HKCH had proposed earlier to decant its termination of pregnancy service to Tsan Yuk Hospital and having taken into account the need to ensure fairness in the use of public resources, he asked whether consideration could be given to putting out the available facilities of Tsan Yuk Hospital for open tender.

47. SFH responded that the Administration had considered the option of decanting HKCH's termination of pregnancy service to Tsan Yuk Hospital. Given that the Queen Mary Hospital ("QMH") would be redeveloped in the coming years, other public hospitals in Hong Kong West Cluster, including, among others, Tsan Yuk Hospital, might be required to accommodate the affected services of QMH during its redevelopment. In addition, it would not be appropriate to tender out the available facilities of Tsan Yuk Hospital when two sites at Wong Chuk Hang and Tai Po reserved for private hospital development had already been put up for tender on 13 April 2012. The proposal might also affect the existing care services provided at Tsan Yuk Hospital which had utilized 70% to 80% of the total floor area of the Hospital.

Handling of medical records

48. Ms Audrey EU asked whether HA could help to keep the medical records of those patients of HKCH whom the Hospital had tried to contact but to no avail, so that these patients could still retrieve their own medical

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records within a reasonable period of time after the closure of HKCH. Holding the view that these records should not be destroyed upon the closure of HKCH, Dr Joseph LEE asked whether consideration could be given to keeping these medical records in the future Electronic Health Record ("eHR") Sharing System developed by the Government so that patients could access the data at a later stage. Mr CHEUNG Man-kwong noted that under the preservation-cum-development proposal for its Central Compound on Lower Albert Road, HKSKH proposed to include, among others, medical facilities in the two new buildings to be constructed at the site. He suggested inviting HKSKH to keep the medical records of patients of HKCH at its new medical facilities for a reasonable period of time.

49. SFH stressed that HKCH, being the owner of the medical records of its patients under law, had the responsibility to contact the patients concerned and make arrangements for them, or their doctors with patients' consent, to obtain copies of the medical records before it closed down. HKCH should also put in place a suitable arrangement so that those patients whom the hospital had tried to contact but to no avail could still have access to their own medical records within a reasonable period of time. It should however be noted that the law had not specified for how long the records should be kept. Reference might be made to the Limitation Ordinance (Cap. 347). The Ordinance stipulated that plaintiff could claim damages for personal injuries resulted from negligence, nuisance or breach of duty up to three years from the date on which the cause of action accrued, or the date (if later) of the plaintiff's knowledge. It implied that the reasonable period for keeping medical records should be more than three years. In the meantime, the Administration was seeking advice from the Office of the Privacy Commissioner for Personal Data on privacy matters concerning medical records held by HKCH.

50. As regards members' suggestions on the handling of medical records, SFH advised that the Administration had to study whether the proposed arrangements were legally in order. He would not rule out any possibilities at this stage, including keeping the medical records of HKCH at the new medical facilities of HKSKH, subject to the consent of HKCH and HKSKH. In response to Mr CHEUNG Man-kwong's enquiry on whether the Administration would take active steps to liaise with HKCH and HKSKH on the handling of HKCH's medical records, SFH advised that this would depend on whether HKCH considered that there was such a need. That said, he assured members that the Administration would ensure that the medical records would be handled properly such that patients of HKCH could have access to their own medical records, regardless of whether they would be kept by HKCH or the Administration having regard to the

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requirements/provisions of relevant laws and regulations, within a reasonable period of time after the closure of HKCH.

Conclusion

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51. In concluding the discussion, the Chairman requested the Administration to revert to the Panel on the development in the next legislative term. SFH agreed.

VI. Report of the Subcommittee on Health Protection Scheme
[LC Paper No. CB(2)2527/11-12]

52. Members noted the report of the Subcommittee on Health Protection Scheme (LC Paper No. CB(2)2527/11-12).

53. Mr CHAN Kin-por requested the Panel to take note of the comments from the Task Force on Healthcare Reform under the Hong Kong Federation of Insurers on the Health Protection Scheme, details of which were set out in its submission (LC Paper No. CB(2)2595/11-12(01)). In particular, the Task Force was of the view that it would be more appropriate to let market force to determine the uptake of private health insurance ("PHI"). According to the Task Force, statistics showed that in the absence of any financial incentives, the membership of individual PHI plans could still achieve an annual growth of 200 000 in 2011.

54. Members supported the recommendations of the Subcommittee as set out under paragraphs 64 and 65 of the report, which included, among others, the recommendation that the Panel should follow up the issue with the Administration in the next legislative term and appoint a subcommittee to assist its monitoring work in this regard if necessary.

55. The Chairman suggested and members agreed to dissolve, with immediate effect, the Subcommittee on Health Protection Scheme.

VII. Any other business

56. SFH took the opportunity to share with members his views on the development of the healthcare system. In gist, SFH was of the view that while the public healthcare system should continue to serve as the safety net for the whole population, a balanced development of both the public and private healthcare sectors was essential to the long-term sustainability of the healthcare system. The outcomes of the various consultation

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exercises on healthcare reform had revealed that the promotion of PHI of a voluntary nature could enable more persons to access private healthcare, thus help relieve the pressure on the public healthcare system and the Government could better focus its resources on target service areas and population groups. In tandem, efforts should continuously be made to further promote public-private partnership in the provision of healthcare and develop a territory-wide eHR Sharing System to enable sharing of patients' medical records among healthcare providers in both the public and private sectors. SFH however stressed that while promoting a balanced development of the public and private healthcare sectors would be high on his agenda, there was a more urgent need to address the long waiting time for public general outpatient services, as well as the manpower constraint and heavy work pressure of the public healthcare sector.

57. This being the last meeting of the Panel in the current term, the Chairman thanked Panel members for their support to the work of the Panel in the past years.

58. There being no other business, the meeting ended at 10:50 am.

Council Business Division 2
Legislative Council Secretariat
21 September 2012