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Legislative Council

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Report of the Panel on Health Services
for submission to the Legislative Council

Purpose

This report gives an account of the work of the Panel on Health Services ("the Panel") during the 2011-2012 Legislative Council ("LegCo") session. It will be tabled at the Council meeting of 11 July 2012 in accordance with Rule 77(14) of the Rules of Procedure.

The Panel

2. The Panel was formed by resolution of the Council on 8 July 1998 and as amended on 20 December 2000, 9 October 2002, 11 July 2007 and 2 July 2008 for the purpose of monitoring and examining Government policies and issues of public concern relating to health services matters. The terms of reference of the Panel are in **Appendix I**.

3. The Panel comprises 20 members, with Dr Hon LEUNG Ka-lau and Dr Hon Joseph LEE Kok-long elected as Chairman and Deputy Chairman respectively. The membership list of the Panel is in **Appendix II**.

Major work

Use of obstetric services by non-local women

4. The use of obstetric services by non-local women was high on the agenda of the Panel. Noting that the number of live births born to Mainland women in Hong Kong reached a record high of 43 982 in 2011, among whom 35 736 (or 81%) were fathered by non-residents, members were gravely concerned about the effectiveness of the existing measures in controlling the use of obstetric services by non-local women. In particular, members noted that following the decision by the Hospital Authority ("HA") to cease accepting booking from non-local women from 8 April 2011 until the end of the year, the

number of non-local women delivering at public hospitals via the Accident and Emergency Departments ("AEDs") surged from 86 in April 2011 to 204 in December 2011. As the fees of emergency delivery by non-local women in public hospitals might still be lower than those charged by private hospitals, members were concerned that in order to lower the cost of giving birth in Hong Kong, non-local women might obtain the confirmation certificate with a private hospital booking but sought admission via public hospital AEDs for delivery.

5. According to the Administration, HA would review the fees for deliveries by Non-eligible Persons at AEDs, with a view to raising the fees of emergency delivery to a sufficient level to deter Mainland pregnant women from seeking emergency admission to AEDs for delivery. The review would take into account the costs of services as well as the price being charged for comparable services by private hospitals.

6. While agreeing that sufficient places in public hospitals should be reserved for delivery by local women, members took the view that Mainland spouses of Hong Kong residents seeking obstetric services should be treated differently from those seeking other types of public healthcare services, as the babies born to the former were Hong Kong permanent residents by birth. In the light of this, a separate policy should be formulated to enable the former to enjoy public obstetric services as local pregnant women. Given that the number of live births born to Mainland women and fathered by Hong Kong residents maintained at the level of 6 000 annually in the past three years while the quota for non-local pregnant women giving births in Hong Kong was 35 000 in 2011, the service demand from Mainland spouses of Hong Kong residents could be absorbed by the healthcare system. The Panel passed two motions at its meeting on 12 March 2012, requesting the Government to amend its policy immediately to allow Mainland women whose spouses were Hong Kong residents to wait for delivery places in Hong Kong, cancel the quota for Mainland women whose spouses were not Hong Kong residents, and ensure the provision of sufficient obstetric services in the public healthcare system to local pregnant women and Mainland pregnant women whose spouses were Hong Kong residents.

Monitoring of charging policy of private hospitals for obstetric services

7. The Panel received a briefing from the Administration on the monitoring of the charging policy of private hospitals for obstetric services. Members noted that private hospitals were subject to regulation by the Department of Health ("DH") under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) on matters of accommodation, staffing or equipment. To ensure the provision of quality healthcare services to patients, DH 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. Members expressed dissatisfaction with the lack of statutory regulation in the charging and operation of the non-profit-making private hospitals. They urged the Administration to review the Ordinance in order to regulate private hospitals effectively.

8. Members also expressed grave concern about the charitable status of private hospitals. They requested the Administration to look squarely at the problem arising from the practice of some tax-exempt private hospitals paying bonuses to their staff members. In their view, this practice might cause further brain drain from the public to private hospitals, leading to increases in staff costs and service charges. They called on the Administration to closely monitor the tax-exempt private hospitals to ensure that their profits would be applied for charitable purposes only.

9. According to the Administration, charitable bodies applying for tax exemption were required by the Inland Revenue Department ("IRD") to have a governing instrument stating their objects precisely and clearly. IRD would conduct regular reviews on tax-exempt charities to ascertain whether their objects were still of a charitable nature and whether their activities were compatible with their stated objects.

10. Noting that some private hospitals had increased their charges for obstetric services on admission before delivery, members urged the Administration to enhance regulation over private hospitals and provide an avenue for the aggrieved pregnant women to seek redress. They also called on the Administration to put in place a mechanism to ensure the provision of reasonably priced and adequate private obstetric services for local pregnant women.

11. The Administration stressed that 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 women when spare service capacity was available. DH would conduct inspections to private hospitals to monitor compliance of their operation with the relevant legislation and regulations. The Administration had no statutory power to intervene the level of charges of private hospitals. However, the Code of Practice required private hospitals to have a schedule of charges for reference by the public. According to the Administration, many private hospitals had publicized their schedules of charges on their websites.

Public and private hospital development

Expansion of United Christian Hospital and redevelopment of Kwong Wah Hospital

12. Members were deeply concerned about the overall capacity of the healthcare system to cope with the increasing service demand arising from the ageing population. They were supportive of the Administration's proposal of expanding the United Christian Hospital, which members had long called for, to improve and enhance its facilities to provide adequate space and capacity to cope with the anticipated growth in demand for both ambulatory and inpatient services in the Kowloon East cluster. Members were also supportive of the redevelopment of the Kwong Wah Hospital which aimed to enhance the operational efficiency of the hospital, as well as to provide a patient-oriented environment with adequate capacity and capability for the delivery of holistic and seamless healthcare services. Many members stressed the need to ensure that patients would not be affected during the construction period. Noting that the main works of the two hospitals were expected to complete in 2021 and 2022 respectively, there was a strong request from members for shortening the completion period of these projects. The Administration assured members that it would endeavour to shorten the time required for completion of the projects in the detailed design and planning stage.

Establishment of a multi-partite Medical Centre of Excellence in Paediatrics

13. The Panel examined the Administration's proposal to establish a multi-partite Medical Centre of Excellence in Paediatrics at Kai Tak ("CEP"). According to the Administration, subject to funding approval, construction works of CEP would start in 2013 with a target date for completion by 2017. The target of the Administration was to commence services at CEP by phases starting from mid-2018.

14. Noting that CEP, which was the first of its kind in Hong Kong, would bring together medical professionals in the public, private and academic sectors from both within and outside Hong Kong, and partner with major international medical centres, some members expressed concern on the management framework as well as the sources of funding for CEP. According to the Administration, while CEP would be a public hospital placed under the management of HA, its management structure would be different from that of existing public hospitals. CEP would be governed by a hospital governing committee/board of directors comprising experts from the public and private healthcare sectors, academics from the medical schools of The University of Hong Kong and The Chinese University of Hong Kong, as well as representatives from relevant stakeholders. As regards the sources of funding, members were given to understand that CEP would offer private paediatrics

services, with fees and charges to be set with reference to the market rate. Government appropriation to CEP through HA would only be used on the provision of medical services. Research activities to be conducted by CEP would be funded by other financial sources, such as the Health and Medical Research Fund set up under the Food and Health Bureau. HA would continue to be responsible for the training and development of its medical and healthcare practitioners.

Land disposal arrangement for the development of private hospitals at Wong Chuk Hang and Tai Po

15. In the course of discussion on the capacity of the private healthcare sector, members pointed out that the healthcare system in Hong Kong was overly reliant on public hospital services, which were provided at a highly subsidized rate of 95%. They urged the Administration to take effective measures to address the imbalance between the public and private sectors in hospital services. According to the Administration, four sites at Wong Chuk Hang, Tseung Kwan O, Tai Po and Lantau had been reserved for private hospital development. The two reserved sites at Wong Chuk Hang and Tai Po were put out for tender on 13 April 2012.

16. Members noted that the new hospitals to be developed at these two sites would be required to comply with a set of performance obligations, covering, among others, land use, bed capacity, service scope, price transparency, service target, service standard and reporting. Many members were of the view that the minimum percentage of inpatient bed days for use by local residents per year should be increased from the proposed 50% to 70% in order to ensure that the services of the new private hospitals would be offered primarily to local residents. They also stressed the need to promote Chinese medicines in the new private hospitals. Some members proposed that consideration be given to granting additional scores for tenders providing Chinese medicines services in the new hospitals. According to the Administration, tenderers would score marks on the basis of the merits of their service provision proposals. In order to encourage the hospitals to target their service to local residents, additional scores would be given for a higher percentage commitment.

17. Noting that the tenancy of the two sites would have a term of 50 years, members were concerned about the monitoring of the performance of the private hospitals to be developed at these two sites. Some members were of the view that the deterrent effect of the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance was grossly inadequate as each offence under the Ordinance was liable on summary conviction to a fine of $1,000 only. Pointing out that private hospitals had derived hefty profits from their business, some members considered the imposition of financial penalties not an effective means to ensure compliance with the Ordinance and the requirements stipulated

in the land lease.

18. According to the Administration, to facilitate monitoring of the operations of the new private hospitals, the successful tenderer would be required to enter into, in addition to the land lease, a service deed with the Government. The service deed would incorporate the successful tenderer's proposals for the operation of the private hospital. A number of measures would be made available to the Government if the successful tenderer breached any of its obligations, such as the right to require the successful tenderer to implement a cure plan and pay liquidated damages, the right to exercise step-in rights to temporarily take partial or total control of the hospital and the right to terminate the service deed. The Government might also resort to the performance guarantee and bank bond provided by the successful tenderer. In the Administration's view, the above measures should be sufficient for the purpose of ensuring compliance with the Government requirements.

Developing electronic health record sharing

19. The Panel continued to follow up on the subject of electronic healthcare record ("eHR") sharing. Members expressed grave concern about the privacy of patients' data. They urged the Administration to take measures to protect the privacy of data as well as to guard against data loss and damage. Noting that the eHR sharing system would comprise standalone electronic medical/patient record ("eMR/ePR") systems adopted by individual healthcare providers, members also expressed concern about the accuracy of patients' health data in the eHR sharing system when there were data input errors in individual eMR/ePR systems.

20. Some members expressed concern about the participation of private doctors in eHR sharing as some private doctors might lack the hardware and technical skills for connection to the eHR sharing platform. There was a suggestion that the Administration should consider creating incentives for healthcare providers to participate in eHR sharing, such as capping the costs of the hardware and software to be incurred by healthcare providers for adopting their own eMR/ePR systems and connecting to the eHR sharing platform.

21. According to the Administration, the eHR sharing system would be hosted in a secure platform with multiple firewalls, intrusion detection tools and industry leading encryption technology to protect patients' health data. While it would be the responsibility of the healthcare professionals to conduct data checks after inputting or correcting eHR data to ensure data accuracy, a comprehensive security and audit framework would be established to ensure safe and secure operation of the eHR sharing system. Members were also given to understand that the costs to be borne by private healthcare providers for joining the eHR sharing system would not be substantial as the Administration

would take up the system development cost. The Administration would also provide training and technical support to the private sector to facilitate their participation in eHR sharing.

22. Some members took the view that patients should take greater ownership of their medical records under the eHR sharing system. They were worried that the participating healthcare providers might not upload a complete and accurate set of medical records of their patients onto the eHR sharing system. They suggested that participating healthcare providers should be held legally liable for failing to input complete records of their patients under the eHR sharing system.

23. Some members held the view that healthcare providers could, at the request of patients, conceal some categories of sensitive eHR sharable data from being automatically accessed by other healthcare providers, i.e. the provision of a "safe deposit box" to allow a separate storage of certain patient data. They considered that access to sensitive data, such as information relating to the mental health of patients, should be restricted to only relevant healthcare professionals. Patients should also be allowed to add additional access control device, encryption or other safeguards for protecting sensitive data.

24. According to the Administration, there were divergent views on the issue of allowing additional access control or exclusion of particular data from the eHR sharable scope. While acknowledging that some patient groups would wish to have enhanced access control on sensitive health data, the Administration considered it necessary to assess the implication of the exclusion of some data by the patients in eHR. Under the proposed eHR sharing system, only relevant healthcare professionals could view patients' records on a "need-to-know" basis, and all participating healthcare providers would be required to exercise proper internal access control. Taking note of members' views, the Administration would further study the subject with reference to overseas experience.

Financial assistance for needy patients to meet expenses on self-financed drugs

25. The Panel received a briefing from the Administration on the financial assistance provided for needy patients to meet expenses on self-financed drugs. Members noted that financial assistance in this regard was provided through the Samaritan Fund ("SMF") and the Community Care Fund ("CCF"). To obtain financial assistance from SMF, patients had to pass a household-based financial assessment. Many members expressed objection to the household-based financial assessment requirement. In their view, the financial assessment should be based on individual financial circumstances instead of the applicant's household income. They strongly urged the Administration to abolish the requirement.

26. According to the Administration, the rationale for adopting a household-based financial assessment was to encourage family members to support each other. The same principle was adopted by other safety nets funded by public money such as the Comprehensive Social Security Assistance, legal aid and education subsidies. The Administration had no intention of changing the policy at this stage.

27. Some members were deeply concerned about the financial burden imposed by the extremely expensive self-financed drugs on the patients. They held a strong view that all life-saving drugs with proven efficacy should be provided by HA at standard fees and charges, rather than being classified as self-financed drugs with safety net. They called on the Administration to reposition the 17 self-financed drugs as special drugs in the Drug Formulary. While noting HA's proposal to relax the assessment criteria by introducing a deductible allowance from the disposable capital of a household, many members held the view that the Administration should be more generous in setting the amount of allowance deductible to benefit more needy patients. A discretion mechanism should also be put in place to help those patients who fell marginally outside the safety net to pass the financial assessment.

28. While members in general were supportive of the proposed injection of $10 billion into SMF, some members expressed concern about the projected drop in the amount of donations to SMF. They requested the Administration to make use of the $10 billion grant to generate investment return to sustain the operation of SMF. Some members also urged the Administration to provide a tax deduction for drug expenses incurred by chronic patients.

29. There was a view that the Administration should enhance the transparency of the operation of SMF, such as establishing a consultation mechanism with patient groups to gauge their views on changes to SMF and making public the evaluation and decisions of the Samaritan Fund Management Committee and the Medical Services Development Committee of the HA Board on the inclusion of self-financed drugs into the scope of SMF. Some members also called on the Administration to conduct a comprehensive review of SMF.

30. The Administration stressed that the drug list in the Drug Formulary was regularly reviewed by the HA Drug Advisory Committee and the HA Drug Utilization Review Committee. The committees would give regard to the principles of efficacy, safety and cost-effectiveness when reviewing individual drugs. HA had already implemented a number of measures to enhance the transparency of its overall drug policy and utilization, including putting in place a consultation mechanism with patient groups to gauge their views twice a year on the formulation and changes to the scope of the Drug Formulary and SMF.

31. In June 2012, the Administration informed the Panel that HA proposed to regularize CCF's Medical Assistance Programme Second Phase into SMF. Upon regularization, HA patients who originally failed SMF's financial assessment marginally would be covered under the safety net of SMF.

Health Protection Scheme

32. The Panel continued to follow up on the voluntary Health Protection Scheme ("HPS") under the Healthcare Reform Second Stage Public Consultation. Members were gravely concerned about the impact of HPS on public healthcare services as well as the healthcare manpower for the sustainable development of both the public and private healthcare sectors. While noting that the proposed HPS might bring about improvements to the private health insurance market and offer more choices of private healthcare services as an alternative to public healthcare services, members expressed reservations and divergent views in many aspects of HPS such as the incentives to encourage subscription and use of the $50 billion fiscal reserve earmarked to support healthcare reform. To enable more focused discussion, the Panel agreed at its meeting on 8 August 2011 to appoint a subcommittee to study issues relating to HPS. With the approval of House Committee, the Subcommittee on Health Protection Scheme activated in February 2012.

33. Before the activation of the Subcommittee, the Panel continued to examine the proposed HPS as well as the staffing proposal of creating two supernumerary directorate posts for leading and overseeing a dedicated and time-limited Health Protection Scheme Office ("HPS Office"). Noting the divergent public opinions on the features of HPS and its implementation, some members did not accept the proposed HPS and considered it not opportune to consider the related directorate staffing proposal to take forward HPS. Some other members, however, were in support of the setting up of a dedicated HPS Office to study and take forward the reform initiatives. There was a suggestion that the HPS Office should be renamed to reflect more accurately the work of the office, which included, among others, reviewing the strategy on healthcare manpower and facilitating healthcare service development.

34. According to the Administration, the first stage consultation on healthcare reform in 2008 revealed a strong public preference for more value-for-money choices of private healthcare services. It was against this background that the proposed HPS was formulated. Given the complex, multi-faceted and inter-woven nature of the tasks involved in taking forward HPS, there was a need to establish a dedicated HPS Office to provide the necessary administrative and executive support. On the naming of the office, the Administration had taken heed of members' views and subsequently renamed the office as the Healthcare Planning and Development Office.

35. Since the commencement of its work in February 2012, the Subcommittee had held six meetings to discuss with the Administration on various issues of concern. These included roles of public funding and health insurance in financing healthcare services, development of healthcare service in Hong Kong, strategic review on healthcare manpower planning and professional development, supervisory framework for HPS and utilization of public funding to facilitate the implementation of HPS. The Subcommittee concluded its work in June 2012 and submitted its report to the Panel in July 2012.

Mechanism for handling medical incidents in private hospitals

36. Members were gravely concerned about the occurrence of medical incidents in private hospitals. They were of the view that the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance and the sentinel event reporting system were paper tigers carrying penalty systems without sufficient deterrent effect. They called on the Administration to conduct a review on the Ordinance. Pointing out the long lead time required by the Administration to review and introduce legislative amendments to the Ordinance, some members stressed the need for the Administration to put in place administrative measures, such as a penalty system and disciplinary actions, to effectively regulate the performance of private hospitals in the interim. The Administration agreed that the scope and depth of the Ordinance had failed to meet the rising public expectation for a mechanism that could effectively monitor the performance of private hospitals. It would conduct a review on the Ordinance which would cover, among other things, the penalty for offences under the Ordinance.

37. Members were given to understand that private hospitals were allowed to develop their own policies and mechanisms to identify, report and manage sentinel events. Pointing out the discrepancies in the interpretation of reportable sentinel events between the Administration and the private hospitals, some members expressed concern that private hospitals might not report to DH all sentinel events occurred. Since it would also be extremely rare for the Director of Health to exercise the statutory power under the Ordinance to cancel registration of a private hospital, members were sceptical of the capability of the Administration to effectively monitor the performance of private hospitals.

38. The Administration assured members that it would review regularly the implementation of the sentinel event reporting system and address the discrepancies in the interpretation of reportable events through enhanced communication, publicity and public education. Members were not satisfied with the Administration's explanation. They considered that an independent statutory Office of Health Service Ombudsman should be established to investigate into the sentinel events occurred in private hospitals, with a view to ensuring that the affected patients would be properly compensated.

Mechanism for handling medical incidents in public hospitals

39. Members were equally concerned about the occurrence of medical incidents in public hospitals. Some members were of the view that the clinical governance system of HA and the improvement measures put in place to avoid occurrence of medical incidents were merely paperwork. Although the Administration had explained that local medical incidents were mainly caused by system and process factors rather than human errors, some members remained of the view that insufficient healthcare manpower of public hospitals was the underlying factor contributing to the occurrence of medical incidents. Given an increasing number of experienced doctors leaving the employ of HA to enter the private market, members expressed grave concern about the quality of public healthcare services. They urged the Administration to put in place effective measures to address the problem of manpower shortage.

40. Members also expressed disappointment at the Administration's failure to respond to their repeated call to establish an independent statutory Office of the Health Service Ombudsman to handle medical incidents occurred in public hospitals. They pointed out 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. Noting that the Administration still considered the existing mechanism effective in handling complaints of medical nature, some members expressed regret that the Administration did not take heed of their suggestion.

Commencement of Undesirable Medical Advertisements (Amendment) Ordinance

41. The Panel received a briefing from the Administration on its plan to commence the provisions in the Undesirable Medical Advertisements (Amendment) Ordinance 2005 related to the control of health claims of orally consumed products on 1 June 2012. While welcoming the commencement of the Amendment Ordinance, some members were of the view 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. Pointing out that the free flow of information on the internet would make health claims easily accessible by the public, some members questioned the effectiveness of imposing restrictions on advertising to certain health claims. They stressed that advertisements making untruthful health claims should be prohibited.

42. Members also expressed grave concern about the regulation of health food products making misleading or exaggerated claims relating to slimming or fat reduction. They were disappointed that the claims made by health food

products relating to slimming or fat reduction were not subject to the regulation of the Amendment Ordinance. They urged the Administration to regulate claims made by health food products to safeguard public health.

43. According to the Administration, 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. In the Administration's view, since the risk of delayed proper treatment of diseases due to orally consumed products with claims relating to slimming or fat reduction was relatively low, such claims were not included under the purview of the Amendment Ordinance.

Tobacco control

44. The Administration reverted to the Panel on the progress of tobacco control. Some members pointed out that after the last tobacco duty increase in February 2011, the quantity of duty-paid cigarettes from March to December 2011 decreased by 27% compared with the same period in 2010. They expressed concern that some smokers might switch to consuming illicit cigarettes that might pose an even greater health hazard as many illicit cigarettes were counterfeit cigarettes. They urged the Administration to enhance measures to combat against illicit cigarette activities. Some members were of the view that apart from law enforcement activities, smoking cessation services were equally important. They considered the present smoking cessation services relatively insufficient and urged the Administration to strengthen the cessation services.

45. According to the Administration, illicit cigarette activities had become more active during the initial period after the last tobacco duty increase in February 2011. After strengthening enforcement actions, the overall illicit cigarette situation was under control. The Administration would continue to step up efforts to discourage smoking and protect the public from exposure to second-hand smoke. Resources for DH for smoking prevention and cessation related activities would be increased from about 47 million in 2011-2012 to over 81 million in 2012-2013. The increased resources would be used in enhancing the existing services and providing new services for smoking prevention and cessation in 2012-2013.

46. Some members were of the view that HA doctors, especially specialists in psychiatry should be allowed to prescribe Nicotine Replacement Therapy ("NRT") drugs for their patients where clinically necessary. They proposed that consideration be given to introducing NRT drugs into the Drug Formulary. Noting that the pilot smoking cessation programme involving the use of acupuncture was well received by the programme participants, members requested the Administration to conduct a review on the effectiveness of the

pilot programme as soon as possible and to give consideration to extending the pilot programme to more locations in the territory. According to the Administration, preliminary clinical findings showed that acupuncture was an effective way to quit smoking and no serious side effect was reported. More resources would be allocated to enhance this free smoking cessation programme.

Mental health services

47. The Panel continued to follow up on the subject of mental health services. Members were of the view that the existing mental health services fell far short of meeting the needs of mentally ill persons and ex-mentally ill persons due to the lack of a comprehensive policy on mental health. They expressed disappointment at the Administration's failure to provide a blueprint for the long-term development of mental health services.

48. Members were also deeply concerned about communication among HA and relevant government departments. They urged HA to forge closer collaboration with other service providers in the districts in providing support services for persons with mental health problems, and to improve communication with different government departments to enable timely intervention for patients having signs of relapse of mental illness.

49. Members also considered the provision of one-stop community support services most important for the discharged mental patients and their families and carers. While expressing support for the establishment of the Integrated Community Centres for Mental Wellness ("ICCMWs") which aimed to provide comprehensive, district-based and one-stop community support services for ex-mentally ill patients and their families, members were concerned about the difficulties encountered by ICCMWs, such as the lack of permanent accommodation, opposition from local residents and shortage of manpower. They urged the Administration to strengthen the manpower of medical social workers and step up its efforts in identifying suitable premises for those ICCMWs without permanent accommodation.

50. The Administration stressed that it was committed to promoting mental health through a comprehensive range of mental health services, including prevention, early identification, medical treatment and rehabilitation services. ICCMWs would be allocated with additional provisions totaling $48 million in 2011-2012 and 2012-2013 to strengthen their manpower. The total amount of resources allocated for ICCMWs would be over $180 million in 2012-2013. Among the 24 ICCMWs, 15 had identified permanent accommodation. The Administration assured members that it would continue to proactively identify suitable premises for the remaining nine ICCMWs.

Development of a Hong Kong Code of Marketing of Breastmilk Substitutes

51. The Panel received a briefing from the Administration on the development of a Hong Kong Code of Marketing of Breastmilk Substitutes ("the Hong Kong Code") and the views of deputations on the subject. While supporting the introduction of regulation on the advertising and marketing of breastmilk substitutes and related products, members expressed disappointment at the slow progress of the formulation of the Hong Kong Code. They were also dissatisfied with the implementation of the Code in the form of voluntary guidelines, as it would be difficult for the Administration to ensure the trade's compliance with the Code. They called on the Administration to make the Hong Kong Code a mandatory requirement and introduce legislation to regulate formula milk.

52. Members also expressed grave concern about the misleading and exaggerated advertising and marketing claims made by some formula milk suppliers. They considered that misleading and exaggerated claims should be prohibited and advertising and marketing claims making untruthful nutrition and health claims should be subject to regulation. Some members considered that to protect and support breastfeeding, the promotion of infant formula for infants under the age of six months should be prohibited.

53. Members were advised that a taskforce was set up under DH in June 2010 to develop the Hong Kong Code. While the taskforce had a multi-disciplinary membership drawn from representatives of community organizations, professional bodies, academia and Government departments, members noted that the trade was not invited to join the taskforce. Some members were of the view that the views of the trade should be reflected in the Hong Kong Code during the drafting process. They urged the Administration to consult the trade and collect the views of stakeholders during the drafting process as well as before the implementation of the Hong Kong Code.

54. While recognizing the benefits of breastfeeding, members were deeply concerned about the problems encountered by mothers to establish and sustain exclusive breastfeeding, such as a lack of babycare rooms in office buildings and shopping malls. They urged the Administration to step up its efforts in promoting breastfeeding and re-consider introducing legislation to make the provision of babycare rooms a mandatory requirement for office buildings and shopping malls so as to promote and encourage breastfeeding.

55. The Administration stressed the Government's commitment to promoting, protecting and supporting breastfeeding in Hong Kong. To provide more support to breastfeeding mothers, the Administration had been actively promoting the provision of babycare rooms in public places and private premises. To this end, the Advisory Guidelines on Babycare Facilities were

introduced in August 2008 and the Practice Note on the Provision of Babycare Rooms in Commercial Buildings was introduced in February 2009. HA had also stopped providing samples of breastmilk substitutes to newborns in their obstetric departments since 1 April 2010.

56. The Administration further advised members that the taskforce was in the process of drafting the Hong Kong Code. Upon completion of the drafting work, DH would consult the trade and relevant stakeholders on the implementation of the Code. Briefing sessions would also be arranged for manufacturers, distributors, importers, retailers and other relevant parties.

Subcommittee on Registration of Proprietary Chinese Medicines

57. The Panel set up a subcommittee in March 2011 to study issues relating to the mandatory registration of proprietary Chinese medicines ("pCm"). The approval of House Committee was obtained for the Subcommittee on Registration of Proprietary Chinese Medicines to commence work in June 2011 and for it to continue to work in the 2011-2012 session in accordance with House Rule 26(c) on 8 April 2011 and 21 October 2011 respectively.

58. The Subcommittee held four meetings, including two in the 2010-2011 session, to discuss with the Administration on various issues of concern. These included implementation of mandatory registration of pCms, classification categories of pCms, support for the pCm trade and implementation of the label and package insert requirements. The Subcommittee had concluded its work and submitted its report to the Panel in February 2012. The Panel noted the report of the Subcommittee, and supported its recommendations, which included, among others, requiring the Administration to report to the Panel on the implementation progress of the mandatory registration of pCms and label and package insert requirements at regular intervals.

Proposal for setting up a Health and Medical Research Fund

59. The Panel examined the Administration's proposals to consolidate the existing Health and Health Services Research Fund ("HHSRF") and Research Fund for the Control of Infectious Diseases ("RFCID") administered by the Food and Health Bureau into a new Health and Medical Research Fund ("HMRF"); and increase the non-recurrent commitment of the consolidated HMRF by $1,000 million to support the broadened funding scope for health and medical research in Hong Kong, in addition to the existing funding scope of HHSRF and RFCID. While expressing support for the setting up of HMRF, members considered it important to ensure openness, fairness and transparency of the research grant review process. Noting that the Research Council, which was responsible for the administration of HMRF, comprised only healthcare professionals, there was a suggestion that lay persons should be appointed to the

Research Council. Some members were also of the view that research in the area of Chinese medicines should be further promoted.

60. Some members also suggested that the Administration should lower the grant application threshold so that more small-scale local clinical studies proposed by frontline healthcare professionals would be funded under HMRF. There was also a view that the Administration should raise the grant ceiling of $1 million so as to attract more large-scale research. In the Administration's view, it was appropriate to set the grant ceiling for single individual research project at $1 million. For cases such as multicentre collaborations and projects or medical research infrastructure, higher grants would be considered where justified.

Other issues discussed

61. Other issues discussed by the Panel included pilot project on enhancing radiological investigation services through collaboration with the private sector, replacement of a Thermoluminescent Dosimetry System and a Standard Radiological Dosimetry Calibration Facility in DH, issues relating to healthcare personnel infected with HIV and Chinese medicinal products containing ingredients from bear gall bladders.

Meetings held

62. During the period between October 2011 and June 2012, the Panel held a total of 16 meetings, including two joint meetings with the Panel on Welfare Services.

Council Business Division 2
Legislative Council Secretariat
5 July 2012

Appendix I

Legislative Council

Panel on Health Services

Terms of Reference

1. To monitor and examine Government policies and issues of public concern relating to medical and health services.

2. To provide a forum for the exchange and dissemination of views on the above policy matters.

3. To receive briefings and to formulate views on any major legislative or financial proposals in respect of the above policy areas prior to their formal introduction to the Council or Finance Committee.

4. To monitor and examine, to the extent it considers necessary, the above policy matters referred to it by a member of the Panel or by the House Committee.

5. To make reports to the Council or to the House Committee as required by the Rules of Procedure.

Appendix II

Panel on Health Services

Membership list for 2011 - 2012 session

Chairman	Dr Hon LEUNG Ka-lau
Deputy Chairman	Dr Hon Joseph LEE Kok-long, SBS, JP
Members	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, SBS, JP Prof Hon Patrick LAU Sau-shing, SBS, JP Hon Cyd HO Sau-lan Hon CHAN Hak-kan, JP Hon CHAN Kin-por, BBS, JP Hon CHEUNG Kwok-che Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou Dr Hon Samson TAM Wai-ho, JP Hon Alan LEONG Kah-kit, SC (Total : 20 Members)
Clerk	Ms Elyssa WONG
Legal adviser	Miss Evelyn LEE
Date	3 July 2012