立法會
Legislative Council

LC Paper No. CB(2)1735/12-13
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 18 March 2013, at 4:30 pm
in Conference Room 3 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 Vincent FANG Kang, SBS, JP Hon WONG Ting-kwong, SBS, JP Hon CHAN Kin-por, BBS, JP Dr Hon Priscilla LEUNG Mei-fun, JP Hon Albert CHAN Wai-yip Hon Charles Peter MOK Hon CHAN Han-pan Hon Alice MAK Mei-kuen, JP Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung Dr Hon Helena WONG Pik-wan Dr Hon Elizabeth QUAT, JP Hon POON Siu-ping, BBS, MH Dr Hon CHIANG Lai-wan, JP
Members absent	:	Hon CHEUNG Kwok-che Hon Mrs Regina IP LAU Suk-yee, GBS, JP
Members attending	:	Hon WONG Kwok-hing, MH Hon CHAN Yuen-han, SBS, JP Hon KWOK Wai-keung Hon TANG Ka-piu

Public Officers attending	:	Item IV Dr KO Wing-man, BBS, JP Secretary for Food and Health Miss Janice TSE, JP Deputy Secretary for Food and Health (Health)1 Dr Ronald LAM Assistant Director (Traditional Chinese Medicine) Department of Health Dr Cecilia PANG Biotechnology Director Innovation and Technology Commission Items V, VI and VII Professor Sophia CHAN, JP Under Secretary for Food and Health Items V and VII Ms Angela LEE Principal Assistant Secretary for Food and Health (Health)2 Dr CHEUNG Wai-lun Director (Cluster Services) Hospital Authority Item V Mr TAO Kei-hung Deputy Project Manager/ Major Works (1) Highways Department Dr LO Su-vui Director (Strategy & Planning) Hospital Authority Dr C T HUNG Cluster Chief Executive, Kowloon Central Cluster Hospital Authority

Mr Donald LI
Chief Manager (Capital Planning)
Hospital Authority

Dr Jenny LAM Mei-yee
Chief Manager (Strategy, Planning & Service Transformation), Kowloon Central Cluster
Hospital Authority

Item VI

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

Mr Sidney CHAN, JP
Head (eHealth Record), eHealth Record Office
Food and Health Bureau

Ms Ida LEE
Deputy Head (eHealth Record), eHealth Record Office
Food and Health Bureau

Dr N T CHEUNG
Consultant (eHealth), eHealth Record Office
Food and Health Bureau

Item VII

Dr H W LIU
Director (Quality & Safety)
Hospital Authority

Dr K H LEE
Chief Manager (Cluster Performance)
Hospital Authority

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

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

Ms Priscilla LAU
Council Secretary (2) 5

Ms Michelle LEE
Legislative Assistant (2) 5

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I. Confirmation of minutes
[LC Paper No. CB(2)759/12-13]

The minutes of the meeting held on 21 January 2013 were confirmed.

II. Information paper(s) issued since the last meeting
[LC Paper Nos. CB(2)793/12-13(01) and CB(2)819/12-13(01)]

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

(a) Information paper provided by the Administration on the tender result for the development of private hospitals at Wong Chuk Hang and Tai Po; and

(b) Information paper provided by the Administration on the revised outpatient charges for non-eligible persons charged by the Department of Health ("DH") which were pegged to the Hospital Authority ("HA") rates.

III. Items for discussion at the next meeting
[LC Paper Nos. CB(2)758/12-13(01) and (02), CB(2)784/12-13(01) and (02) and CB(2)805/12-13(01)]

3. The Chairman sought members' views on whether the following items proposed by the Administration, Dr Joseph LEE and Dr KWOK Ka-ki respectively should all be included on the agenda for the next regular meeting scheduled for 15 April 2013 at 4:30 pm -

(a) "Development of a Centre of Excellence in Paediatrics ("CEP")" which was proposed by the Administration;

(b) "Strategy and management of severe respiratory disease associated with novel coronavirus" which was proposed by Dr Joseph LEE in his letter dated 11 March 2013 (LC Paper No. CB(2)784/12-13(01));

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(c) "Regulation of healthcare intermediary service" which was proposed by Dr KWOK Ka-ki in his letter dated 11 March 2013 (LC Paper No. CB(2)784/12-13(02)); and

(d) "Private hospital development" which was proposed by Dr KWOK Ka-ki in his letter dated 14 March 2013 (LC Paper No. CB(2)805/12-13(01)).

The Chairman advised that subject to members' views, the next regular meeting would be extended for one hour to 7:30 pm to allow sufficient time for discussion of four agenda items at the meeting.

4. Dr Joseph LEE expressed reservations about holding a three-hour meeting. Expressing concern about the preparedness of the Administration to safeguard Hong Kong against severe respiratory disease associated with novel coronavirus, he was of the view that there was an urgent need to discuss the measures put in place by the Administration for the prevention and control of the disease. Dr KWOK Ka-ki was of similar view, adding that the subject on private hospital development should also be included on the agenda for the next regular meeting. He sought clarification from the Administration on whether there was a pressing need to discuss the development of CEP at the April meeting. Secretary for Food and Health ("SFH") advised that the Administration had invited tender for development of CEP in April 2012 and the tender assessment would be completed in March 2013. It planned to seek members' views on the relevant funding proposal before submission to the Public Works Subcommittee and the Finance Committee of the Legislative Council ("LegCo").

5. Dr KWOK Ka-ki suggested that relevant stakeholders, including the Hong Kong Medical Association, patient groups and the insurance industry, should be invited to give views on the subject on regulation of healthcare intermediary service. To allow time for the deputations to prepare for their attendance, the discussion on the subject could be held at the regular meeting of the Panel scheduled for 20 May 2013. Members did not raise objection.

6. Noting members' views, the Chairman concluded that the Panel would discuss items (a), (b) and (d) at the next regular meeting.

(*Post-meeting note:* On the instruction of the Chairman, the item "Strategy and management of severe respiratory disease associated with novel coronavirus" was deleted from the agenda for the April regular meeting as the issue had already been discussed at the Panel's

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special meeting on 8 April 2013 which was arranged after the meeting.)

IV. Development of Chinese medicine

[LC Paper Nos. CB(2)758/12-13(03) and (04)]

7. SFH briefed members on the work of the Government for development of Chinese medicine in Hong Kong, details of which were set out in the Administration's paper (LC Paper No. CB(2)758/12-13(03)).

8. Members noted the background brief entitled "Development of Chinese medicine" (LC Paper No. CB(2)758/12-13(04)) prepared by the LegCo Secretariat.

Directions for the development of Chinese medicine in Hong Kong

9. Mr POON Siu-ping noted with concern that the newly set up Chinese Medicine Development Committee ("CMDC"), which was chaired by SFH to study the policies and measures to further the development of Chinese medicine, had held its first meeting on 4 March 2013 but no timeframe had been formulated for the completion of its study. SFH responded that although there had yet been a concrete timetable for such a major development at this stage, the Administration would endeavour to take forward the development of Chinese medicine in Hong Kong as soon as practicable.

10. Dr Joseph LEE considered that the Administration's first and foremost task should be to make it clear whether the healthcare system of Hong Kong would run on a dual track basis encompassing both Chinese and Western medicine, and if so, the positioning of Chinese medicine in primary, secondary and tertiary care. Noting that one of the focus areas of CMDC was to work with HA, related healthcare service and research organizations to identify priority and focused service areas to be the pilot areas for the provision of integrated Chinese and Western medical services within the public healthcare system, Mr CHAN Kin-por sought elaboration in this regard. Dr Helena WONG was of the view that the Administration should first determine the role of Chinese medicine in the overall healthcare system, including its interface with Western medicine, before promoting its development. Mr Albert CHAN asked whether consideration could be given to adopting the mode of development of Chinese medicine in the United States whereby some Chinese medicine practices, such as acupuncture, formed part of the mainstream Western medical services. Mr CHAN Han-pan considered that as a first step, Chinese medicine

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should be classified as a supplementary treatment in the public healthcare system so that, where appropriate, doctors could make referral for patients to receive the treatment.

11. Agreeing with the need to map out the positioning of Chinese medicine in the healthcare system, SFH advised that the Administration would engage the Western and Chinese medicine sectors to examine the direction for developing Chinese medicine in Hong Kong, in particular the provision of integrated Chinese and Western medical services. It should also be noted that throughout the course of developing Chinese medicine in Hong Kong, it had been generally agreed by the Chinese medicine profession that a general practice approach should be adopted before considering the development of medical specialization of Chinese medicine practitioners ("CMPs"). While taking note of Mr CHAN Han-pan's suggestion, SFH said that he would regard Chinese medicine as one of the components, instead of a supplementary treatment, in future hospital services, involving close collaboration with Western medicine in both clinical and non-clinical settings.

12. Dr Helena WONG considered that apart from consulting the trade, the Administration should also gauge the views of members of the public in order to ensure that the development would meet their treatment needs. SFH advised that relevant advisory bodies and the regulatory body (i.e. the Chinese Medicine Council of Hong Kong ("CMCHK")) comprised, among others, representatives from the Chinese medicine practice and the Chinese medicines trade, as well as lay persons to represent the interests of the general public and consumers. Relaying the concern of CMPs and the trade of Chinese medicines that their views were not awarded sufficient consideration in CMCHK, Dr Priscilla LEUNG urged the Administration to regulate Chinese medicine from the perspective of Chinese medicine, rather than adopting a Western medicine perspective. There should also be an additional functional constituency seat for Chinese medicine. SFH stressed that the development of Chinese medicine, in particular its integration with Western medicine, was part and parcel of the development of the overall healthcare system. It was a general practice that the composition of the regulatory bodies for various healthcare professionals comprised representatives from both within and outside the profession.

13. Mr Albert CHAN was of the view that the Chinese medicine trade was under-represented in CMDC. While supporting the direction to further the development of the Chinese medicine industry in Hong Kong, Miss CHAN Yuen-han expressed reservations on the composition of CMDC. SFH explained that the appointment of members from other healthcare professions, such as Western medicine doctors, was necessary in

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order to facilitate the active promotion of integrated Chinese and Western medical services in the healthcare system, which was currently western medicine-based.

14. Holding the view that evidence-based medicine practice was a Western medicine standard, Dr Joseph LEE doubted the appropriateness to adopt the evidence-based medicine approach for the development of Chinese medicine in Hong Kong. SFH advised that the adoption of the evidence-based medicine approach in Chinese medicine was not completely identical to the evidence-based approach in western medicine. The evidence-based approach in Chinese medicine, which had been broadly accepted, served to ensure the consistency in ingredients, and the availability of scientific evidence on the safety and efficacy of Chinese medicines. Mr KWOK Wai-keung expressed concern that it might not be feasible for CMPs to meet the consistency requirement for the Chinese medicines compounded by them for patients under their direct care, as the ingredients of those Chinese medicines would vary in accordance with the physical conditions of the patients. SFH clarified that it was the proprietary Chinese medicines ("pCm") manufacturers who were required to ensure that their products were consistently produced and controlled according to required quality standards.

Training of Chinese medicine personnel

15. Mr CHAN Kin-por opined that the application of Chinese medicine in health maintenance was widely recognized. Given that a steady supply of local Chinese medicine graduates and the provision of sufficient clinical practice opportunities for these graduates were of utmost importance in supporting the long-term development of the Chinese medicine industry, he was concerned about the student enrollment in University Grants Committee ("UGC")-funded Chinese medicine degree programmes and the employment opportunities of the fresh graduates of these programmes. SFH advised that three local universities were currently offering full-time UGC-funded degree programmes in Chinese medicine, with each providing around 20 intake places in each academic year. To his understanding, these programmes did not encounter difficulties in attracting students and past experience indicated that the students admitted were of high calibre.

16. Dr KWOK Ka-ki enquired whether the Administration would offer courses to the listed CMPs to enhance their professional standard. SFH advised that while transitional arrangements were provided under the registration system of CMPs to enable persons already practising Chinese medicine on 3 January 2000 to become listed CMPs, it was the long-term objective of the Administration that all practising CMPs in Hong Kong

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would become registered CMPs and efforts had been made to encourage listed CMPs to take part in the CMP Licensing Examination to become registered CMPs. Relevant courses were currently provided by the profession for preparing listed CMPs for the Licensing Examination.

17. Mr CHAN Han-pan sought explanation on why listed CMPs who sat for the Licensing Examination were required to possess knowledge outside their main streams of practice, such as Gynaecology of Chinese medicine, in order to pass the Examination. Miss CHAN Yuen-han also expressed concern about the requirements for listed CMPs to become registered CMPs. SFH advised that prior to the enactment of the Chinese Medicine Ordinance (Cap. 549) ("CMO") in 1999 to establish a regulatory regime for Chinese medicine, the Preparatory Committee on Chinese Development broadly consulted the profession on the registration system of CMPs. It was widely agreed by the profession that to ensure the professional standard of CMPs, registered CMPs should master the fundamental and clinical skills of Chinese medicine practice instead of setting up separate registrations for different specialties. Hence, the CMP Licensing Examination was developed to provide a comprehensive professional assessment of the candidates' knowledge of Chinese medicine which included, among others, the basic and clinical subjects of general practice in Chinese medicine.

Development of Chinese medicine hospital

18. Mr CHAN Kin-por asked whether a Chinese medicine hospital would be established in Hong Kong for the provision of inpatient services for members of the public and training grounds for local Chinese medicine graduates. Dr Joseph LEE considered it necessary to establish Chinese medicine hospitals if the Administration decided that Chinese medicine should play a role in tertiary care. Expressing dissatisfaction with the lack of clinical training grounds in the local hospital setting for students of the full-time UGC-funded degree programmes in Chinese medicine, Dr Helena WONG considered that there was a need to establish a Chinese medicine hospital. Mr KWOK Wai-keung was of the view that Hong Kong had already lagged behind Hengqin and Macao in the development of Chinese medicine. He urged the Administration not to drag its feet in establishing a Chinese medicine teaching hospital in Hong Kong. Dr Priscilla LEUNG considered that the Administration should provide a timetable for establishing a Chinese medicine hospital in Hong Kong.

19. SFH advised that the overall strategy of Chinese medicine development in the past had focused on developing Chinese medicine outpatient services. The current-term Government considered that it was time to explore the feasibility to establish Chinese medicine hospitals. This

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was, however, a highly complex subject and would require consensus from the medical professions and a thorough study on various pertinent issues, such as the positioning of Chinese medicine hospitals in the healthcare system, the operation mode, service scope and risk management of Chinese medicine hospitals under the existing legal and administrative framework governing hospitals and medical facilities in Hong Kong. SFH stressed that the Government would consider proposals to build self-financed Chinese medicine hospitals on private land or applications to change land use of land already allocated to the organization proposing to develop a private Chinese medicine hospital at the moment. Mr POON Siu-ping asked whether the Administration would reserve sites for Chinese medicine hospital development. SFH advised that the Administration would identify potential land for development of Chinese medicine hospitals, with a view to ensuring the readiness and availability of suitable land for such development, in case CMDC recommended that a policy to provide government land for development of Chinese medicine hospitals should be put in place.

20. Dr KWOK Ka-ki was concerned about whether future Chinese medicine hospitals in Hong Kong would adopt the operation mode of the Chinese medicine hospitals in the Mainland, whereby CMPs practised therein were allowed to deliver services which were provided by Western medicine doctors in the case of Hong Kong. A case in point was the conduction of joint replacement surgeries. SFH responded that the practice of Western medicine doctors and CMPs in Hong Kong were currently governed by completely separate statutory regulatory regimes with the Medical Council of Hong Kong and CMCHK as the respective regulators, and therefore the operation mode of Chinese medicine hospitals in the Mainland would not be applicable to Hong Kong.

Research and development in Chinese medicines

21. Dr KWOK Ka-ki asked whether the Administration would provide additional funding for research of Chinese medicines to promote the development of evidence-based Chinese medicine. Dr Priscilla LEUNG was concerned about the funding support for research and development ("R&D") projects of Chinese medicine following the disbandment of the Hong Kong Jockey Club Institute of Chinese Medicine ("HKJCICM").

22. SFH advised that the Hong Kong Jockey Club Charities Trust ("HKJCCT") had pledged $500 million funding support for R&D of Chinese medicine in 2001. Upon the announcement of the disbandment of HKJCICM in 2011, HKJCCT had agreed to use the remaining $400 million funding to support non-profit organizations to carry out worthwhile

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Chinese medicines projects in Hong Kong. In addition, the Government had set up the $5 billion Innovation and Technology Fund in late 1999 to fund applied R&D projects of various technology areas, including Chinese medicine.

Standards and testing of Chinese medicines

23. Mr Vincent FANG welcomed the establishment of CMDC to study the policies and measures to further the development of Chinese medicine. Pointing out that Hong Kong had little production of Chinese herbs and many ingredients of local pCm were Chinese herbs imported from the Mainland, he was concerned about the reference standard adopted by DH in developing the Hong Kong Chinese Materia Medica Standards ("HKCMMS") for the commonly used Chinese herbs in Hong Kong. SFH advised that the Administration had maintained close collaboration with the relevant authorities in the Mainland in establishing the safety and quality standards for Chinese herbs. It was expected that the HKCMMS project would cover up to a total of 200 Chinese herbal medicines by 2013.

24. Miss CHAN Yuen-han urged the Administration to promote Hong Kong as a centre for testing and certification of Chinese medicines, which had long been called for by the Hong Kong Federation of Trade Unions, and ensure sufficient supply of professionals in this regard. SFH responded that this was indeed one of the key issues to be studied by CMDC.

Measures governing Chinese medicines traders

25. Expressing dissatisfaction that there had not been any consultation with the trade prior to the setting of the requirement that all existing licensed Chinese medicine traders who were carrying out their business on domestic premises (such as those Chinese herbal medicine retailers and wholesalers who had been operating at Ko Shing Street in Sheung Wan for more than a century) had to relocate to suitable premises by 31 December 2013 in order to continue their business, Mr WONG Kwok-hing urged the Administration to review the requirement. Miss Alice MAK raised a similar concern. Mr KWOK Wai-keung considered the requirement unreasonable, as many small traders who could not afford to relocate to other business premises would be forced to withdraw from the trade.

26. SFH advised that the requirement aimed at ensuring that the trading premises were suitable for Chinese medicines businesses (including the retail and wholesale of Chinese herbal medicines, and the wholesale and

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manufacture of pCm), so as to strengthen the role of Hong Kong as a platform for internationalization of Chinese medicines. The Chinese medicines traders had to take steps to modernize their practice and enhance the quality standards of their products to meet the development of the Chinese medicines industry in Hong Kong. Miss Alice MAK did not subscribe to the Administration's explanation, pointing out that a more effective way was to impose quality control on the processing of raw materials and packaging activities. Pointing out that there had not been any consultation with the trade on the requirement, Mr TANG Ka-piu urged the Administration to extend the grace period to December 2015. SFH stressed that when considering the steps to develop the Chinese medicines industry, the Administration had to take account of the safety and quality of Chinese medicines, in particular Chinese herbal medicines, which were produced, packaged or supplied to members of the public. The trade had been sufficiently consulted on the requirement over a considerable period of time. Due regard had also been given to, among others, the practical difficulty for DH to conduct inspections and take enforcement actions against those Chinese medicines traders that conducted their businesses on domestic premises.

27. Noting that the number of local pCm manufacturers remained small, Dr Joseph LEE doubted the need to take steps to introduce the mandatory Good Manufacturing Practice ("GMP") requirement for manufacturing of pCm. Mr Vincent FANG expressed concern that hundreds of small and medium enterprises of the pCm manufacturing sector lacked the financial strength and expertise to build and operate GMP facilities. He urged the Administration to take the lead in setting up GMP factory premises for use by the pCm manufacturing industry, so that pCm manufacturers in need could apply for tenancy on these premises.

28. SFH advised that the purpose of introducing GMP to pCm manufacturing was to promote the standardization and quality control of pCm manufacturing, and to keep up with international trends of developing GMP for medicinal products. While the Administration could consider the suggestion to provide pCm manufacturers with hardware infrastructural support, the pCm manufacturers also had to take steps to invest and modernize their operation.

Service provided by the public Chinese medicine clinics

29. While agreeing to the need to develop the Chinese medicine services, Mr WONG Kwok-hing considered that the existing arrangement of non-inclusion of the services provided by the public Chinese Medicine Centres for Training and Research (or commonly known as "Chinese medicine

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clinics" ("CMCs")) in the scope of medical and dental benefits for civil service eligible persons ("CSEPs") ("civil service medical benefits") ran contrary to the Administration's policy of promoting the development of Chinese medicine in Hong Kong.

30. SFH pointed out that there were obstacles HA had to overcome before a full introduction of Chinese medicine outpatient services in the public sector. He highlighted that following the announcement to introduce public Chinese medicine outpatient services in 2000, it was not until 2002 that HA decided to adopt a tripartite collaboration model for the provision of such services, under which HA would collaborate with a non-governmental organization ("NGO") and a local university in each of the clinics to provide research-oriented and evidence-based Chinese medicine services. Since 2003, 17 public CMCs had been established so far. The NGOs were responsible for the day-to-day operation of the public CMCs. As such, the services of these CMCs did not form part of the standard services of HA, and fell outside the scope of civil service medical benefits under prevailing policy.

31. Miss Alice MAK asked whether the Administration had any plan to include the services provided by CMCs as part of the standard services of HA. Mr POON Siu-ping and Mr KWOK Wai-keung raised similar questions. Citing the civil service dental benefits provided through the 38 government dental clinics which were reserved for the exclusive use of CSEPs as an example, Mr TANG Ka-piu said that consideration could be given to setting up a CMC under DH for the exclusive use of CSEPs. SFH responded that CMDC would explore, among others, the positioning of Chinese medicine in the public healthcare system in Hong Kong. However, the discussions on the development of Chinese medicine and the provision of Chinese medicine services as part of the medical benefits for CSEPs should be handled separately. The Civil Service Bureau would keep in view any significant changes to the nature and mode of service delivery of CMCs in future that would warrant a review of their implications on the scope of civil service medical benefits.

32. Mr CHAN Han-pan noted that while each CMC would provide at least 20% of the total patient attendances in Chinese medicine general consultation to Comprehensive Social Security Assistance recipients with the fees and charges (including consultation fee and two doses of herbal medicine) waived, the waiver arrangement did not apply to other Chinese medicine services, such as acupuncture, provided by the NGO operators. He considered that CMCs should be run by the Government to demonstrate its commitment to the development of Chinese medicine in Hong Kong. SFH explained that an increase in the provision of Chinese medicine

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outpatient services in the public healthcare system would involve a number of practical issues, such as the operation mode and service scope of these healthcare institutions, which needed to be resolved.

Conclusion

33. In closing, the Chairman requested the Administration to revert to the Panel on the work progress on the development of Chinese medicine in Hong Kong in six to 12 months' time.

V. Reprovisioning of Yaumatei Specialist Clinic at Queen Elizabeth Hospital

[LC Paper Nos. CB(2)758/12-13(05) and (06)]

34. Under Secretary for Food and Health ("USFH") briefed members on the current status of the reprovisioning of Yaumatei Specialist Clinic ("YMTSC") at Queen Elizabeth Hospital ("QEH"), details of which were set out in the Administration's paper (LC Paper No. CB(2)758/12-13(05)).

35. Members noted the background brief entitled "Reprovisioning of Yaumatei Specialist Clinic at Queen Elizabeth Hospital" (LC Paper No. CB(2)758/12-13(06)) prepared by the LegCo Secretariat.

36. Given the inconvenient location of QEH and the large number of daily patient attendances of the existing YMTSC, Miss Alice MAK was concerned about the traffic impact to be brought about by the project. While expressing support for the reprovisioning project, Mr Vincent FANG also expressed concern that the increase in the number of attendances in QEH after the reprovisioning of YMTSC would aggravate the already very heavy people flow of QEH.

37. USFH advised that the scope of the project comprised not only the demolition of the old Specialist Out-patient Clinic Building at QEH for the construction of a 11-storey new Specialist Clinic Building ("the New Building") for reprovisioning the services and facilities of HA currently provided at YMTSC, but also the provision of ancillary facilities including, among others, link bridges as well as taxi and minibus loading/unloading area to facilitate access of patients to the New Building. Chief Manager (Capital Planning), HA ("CM(CP), HA") supplemented that the estimated number of daily patient attendances for the new Building was around 600. Mr Vincent FANG doubted the accuracy of the estimation. Cluster Chief Executive, Kowloon Central Cluster, HA ("CCE/KCC, HA") clarified that the project only covered the reprovisioning of the HA facilities. The

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facilities of DH currently provided within the YMTSC building, including a Maternal and Child Health Centre, Dermatological Clinic and the Methadone Clinic, would be reprovisioned within the same district under separate projects.

38. Miss CHAN Yuen-han was of the view that the reprovisioning of YMTSC at QEH had not taken into account the need of the community for public specialist outpatient services in Yau Ma Tei. She also expressed concern about the workload of the healthcare professionals of QEH, who were already under very heavy pressure of work.

39. USFH explained that it was necessary to demolish YMTSC as it was situated along the proposed tunnel alignment of the proposed Central Kowloon Route ("CKR"). The reprovisioning of the services at YMTSC at the New Building in QEH would provide the opportunity for HA to strengthen and enhance the existing facilities and services for patients through increasing service capacity and provision of more spacious environment for better quality of services to patients. Given that at present, staff members of YMTSC had to go to QEH regularly for delivery of documents, laboratory specimens and x-ray films, the reprovisioning of the services at QEH would enhance operational efficiency as such delivery between the two places would no longer be necessary. This apart, the close proximity of the reprovisioned services at the New building to QEH would facilitate clinical convenience. Miss CHAN Yuen-han maintained the view that the reprovisioning of YMTSC at QEH was undesirable. In response to Mr POON Siu-ping's enquiry about the additional manpower required for the provision of services after the reprovisioning, USFH advised that as the project was a reprovisioning project, it was expected that no additional manpower was required.

40. Dr KWOK Ka-ki sought explanation on the reasons why the number of geriatric day places would remain at 45 places and only eight additional renal dialysis places on top of the existing 17 places would be provided after the reprovisioning of YMTSC at the New Building in QEH, and enquired about the current average waiting time for these services. CCE/KCC, HA advised that the majority of the patients of the existing Geriatric Day Hospital of YMTSC were stroke patients. The current average waiting time for first appointment for stroke patients was two weeks. As regards dialysis treatment, HA would provide additional haemodialysis places for patients with end-stage renal disease in various hospital clusters in 2013-2014 to meet the increasing service demand. HA would review regularly the service needs of the community and where appropriate, allocate additional resources to pressure areas during the annual planning cycles to cope with the increasing service demand.

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41. Dr Helena WONG opined that it would be more appropriate to take forward the reprovisioning project after the release of the results of the phase 2 public engagement exercise for the proposed CKR to collect public views on the detailed design and construction arrangements of CKR, which, according to the Administration, would be available in the third quarter of 2013. She remarked that residents in To Kwa Wan were gravely concerned about the tunnels of CKR to be constructed underneath the buildings in the district, and whether there would be any impact on the structural safety of the old buildings along the tunnel alignment. USFH advised that the Administration had consulted the Community Building Committee of the Yau Tsim Mong District Council on the proposed reprovisioning of YMTSC at QEH on 14 May 2009 and 6 December 2012. Members of the Committee supported the proposed project in both consultations and requested its early implementation.

42. While expressing support for the project, Mr POON Siu-ping sought information on the contingency plan in case of a delay in completing the project to minimize disruption of service to patients. CM(CP), HA assured members that YMTSC would continue operation until the commissioning of the facilities in the New Building at QEH. Subject to funding approval of the Finance Committee, the construction works would start in June 2013 for completion in June 2016.

Conclusion

43. In closing, the Chairman said that members of the Panel were in support of the proposed reprovisioning of YMTSC at QEH.

VI. Electronic health record sharing

[LC Paper Nos. CB(2)758/12-13(07) and (08) and CB(2)835/12-13(01)]

44. Permanent Secretary for Food and Health (Health) ("PSFH(H)") and Deputy Head (eHealth Record), eHealth Record Office briefed members on the progress of implementation of the first stage of the Electronic Health Record ("eHR") Programme; the major features of the Electronic Health Record Sharing System ("eHRSS") Bill; and the proposal to extend two supernumerary directorate posts of the eHR Office in the Health Branch of the Food and Health Bureau ("FHB"), details of which were set out in the Administration's paper (LC Paper No. CB(2)758/12-13(07)) and the powerpoint presentation materials (LC Paper No. CB(2)835/12-13(01)) tabled at the meeting.

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45. Members noted the background brief entitled "Electronic health record sharing system" (LC Paper No. CB(2)758/12-13(08)) prepared by the LegCo Secretariat.

Participation in eHR sharing

46. Noting that not all private hospitals had participated in the pilot runs of the Clinical Management System ("CMS") Adaptation modules, Dr Elizabeth QUAT was concerned about whether all of them would be technically ready for connecting to the eHR sharing platform by 2014. PSFH(H) responded that the Administration had engaged all private hospitals in a task force concerning the deployment of CMS Adaptation modules. It did not envisage any services difficulties for the private hospitals to connect to eHRSS. They might opt to join at their preferred time after the system commenced operation.

47. Mr Charles MOK expressed support for the implementation of eHRSS and the proposal to extend two supernumerary directorate posts of the eHR Office. However, he was concerned about the readiness of private healthcare providers to participate in a two-way eHR sharing, as the current Public Private Interface – electronic Patient Record ("PPI-ePR") sharing pilot project only enabled participating private healthcare providers to view the patients' records in HA subject to patients' consent. PSFH(H) responded that there was no cause for such concern, adding that ongoing promotion and publicity would help enhance private healthcare providers' understanding and technical know-how in this regard.

48. Dr KWOK Ka-ki noted with concern that as at end January 2013, only 279 334 patients and 2 807 private healthcare professionals had enrolled in the PPI-ePR project. While expressing support for eHR sharing, he considered it not cost-effective to introduce eHRSS if its participation rate was so low. He urged the Administration to make active effort to encourage private healthcare providers to participate in eHRSS. Pointing out that some private doctors had reservations about eHR sharing due to the additional operation cost and legal liabilities involved, Dr Elizabeth QUAT sought information about the measures and incentives to be put in place to encourage private healthcare providers, in particular those in solo practices who still preferred to use paper medical records, to participate in eHRSS.

49. PSFH(H) advised that participation in eHRSS would be voluntary in nature. To promote eHR sharing to private healthcare providers, the Administration would incorporate the use of eHR in various subsidized healthcare schemes (e.g. the Elderly Health Care Voucher Pilot Scheme) and public-private-partnership projects. The Administration would also

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ensure the availability of eHR-compatible electronic medical/patient record systems and other health information systems in the market for private doctors, clinics and other healthcare service providers to connect to the eHR sharing platform. Training and technical support would be provided to private healthcare providers to facilitate their participation in eHR sharing. It was believed that the younger generation of private doctors should be less resistant to managing medical records of patients in electronic mode. As regards the expected number of patients enrolled in eHRSS, PSFH(H) advised that patients of HA taking part in the PPI-ePR scheme, elderly persons residing in the residential care homes for the elderly and the newborns would be the initial target participants of eHRSS.

50. Dr Helena WONG said that the Democratic Party was in support of implementing eHRSS. She enquired whether CMPs could participate in eHRSS. PSFH(H) advised that given that CMPs' medical records were mainly in Chinese and many of them preferred to use paper records, CMPs would not be covered in eHRSS at the initial stage. It was expected that with better standardization of terminologies and the inclusion of CMPs in the Elderly Health Care Voucher Pilot Scheme, more CMPs, in particular the younger generation, would become more used to storing medical records in electronic mode. Dr Helena WONG opined that the architectural design of eHRSS should enable the processing of Chinese characters in order to facilitate the coverage of CMPs in the future.

Data access and security

51. Dr Helena WONG was concerned about patients' access to eHR data, and the charges to be imposed thereon. PSFH(H) advised that the Administration respected patients' rights of access to eHR data. A simple application mechanism would be put in place to allow patients to easily gain access to their eHR data. Given that the administrative cost for producing patients' eHR in the future eHRSS would be minimal, it was envisaged that the fee for data access request would not be high.

52. In response to Dr Helena WONG's enquiry about the safeguards against breach of data privacy of eHRSS, PSFH(H) advised that eHRSS was designed to be a closed system. Under the principle of "patient-under-care", healthcare professionals would be required to observe that patients' records would only be accessed and disclosed on a "need-to-know" basis, and their access would be regulated to ensure compliance with the privacy and security requirements of eHRSS. A new criminal sanction would also be introduced specially against unauthorized access to eHRSS with a malicious intent to enhance deterrent effect.

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Manpower support for the implementation of eHRSS

53. Mr Charles MOK was concerned that the implementation of eHRSS would lead to a brain drain of health information technology ("health IT") professionals from HA to private healthcare providers.

54. PSFH(H) said that while HA was serving as the agency for FHB on eHR development, the private information technology ("IT") service providers also saw business opportunities in assisting private clinics to connect to and interface with the eHR sharing platform. The Administration was also formulating an eHR service provider training scheme to enable private IT vendors to provide implementation services to help private clinics deploy CMS On-ramp applications. Consultant (eHealth) supplemented that the Administration was discussing with the tertiary institutions the provision of undergraduate and graduate degree courses in health IT, with a view to building up a larger workforce in the health IT field in the future. Holding the view that the involvement of private IT service providers in the first stage of eHR programme was not high, Dr Elizabeth QUAT called on the Administration to increase the engagement of the IT sector in the subsequent stages of the programme to promote the development of the health IT industry. PSFH(H) advised that while the eHR sharing infrastructure core component would be leveraged upon HA's expertise and know-how in the development of its CMS, the CMS Extension modules would be implemented predominantly through private participation. For instance, consideration could be given to licensing the adapted and extended components and technologies of HA's CMS to IT vendors for their further development and implementation.

55. Referring to the Administration's proposal to extend the two supernumerary directorate posts of the eHR Office up to 31 March 2015 till eHRSS commenced operation, Dr KWOK Ka-ki asked whether the tasks of formulating the eHR legislation and migrating the eHR sharing pilots would have been completed by that time. PSFH(H) advised that the legal framework for operating eHRSS would be in place before eHRSS commenced operation by end of 2014, and the migration plan for PPI-ePR would be executed in 2013-2015. The Administration would take account of the long-term institutional arrangement for the governance, operation and maintenance of the eHR sharing infrastructure, as well as the scope and work plan for the second stage of the eHR programme, when reviewing the continued need of these two posts.

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eHRSS operating body

56. Dr KWOK Ka-ki considered that HA should assume the role of being the eHRSS operating body to leverage the system expertise of HA to provide support for the operation of eHRSS. Pointing out that HA was a user of eHRSS, PSFH(H) advised that the future eHRSS operating body would be empowered to, among others, commission security audits on the relevant electronic record systems and the internal access control systems of participating healthcare providers. While HA would play important supportive role, the plan of the Administration was to appoint a public officer to be the eHR Commissioner for the management, operation and further development of eHRSS at the initial stage.

Conclusion

57. In closing, the Chairman said that members of the Panel were in support of the proposed extension of the two supernumerary directorate posts of the eHR Office.

VII. Accident and emergency services of public hospitals

[LC Paper Nos. CB(2)758/12-13(09) and (10)]

58. USFH briefed members on the provision of Accident and Emergency ("A&E") services of public hospitals in Hong Kong and the measures taken by HA during the winter surge period to meet the service demand in A&E Departments, details of which were set out in the Administration's paper (LC Paper No. CB(2)758/12-13(09)).

59. Members noted the background brief entitled "Accident and emergency services of public hospitals" (LC Paper No. CB(2)758/12-13(10)) prepared by the LegCo Secretariat.

60. Dr Joseph LEE urged the Administration to implement effective measures to reduce the waiting time for treatment of patients whose clinical conditions were triaged as semi-urgent and non-urgent under HA's triage system for A&E services. Holding the view that patients with less urgent clinical conditions could be managed at public general outpatient clinics ("GOPCs"), Dr KWOK Ka-ki asked whether consideration could be given to setting up GOPCs aside the A&E Departments to provide late-night or round-the-clock general outpatient services for semi-urgent and non-urgent cases.

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61. USFH advised that the current average waiting time for patients classified as semi-urgent and non-urgent cases were 76 minutes and 103 minutes respectively. At present, 23 out of the 74 GOPCs operated by HA provided evening outpatient services until 10:00 pm. Director (Cluster Services), HA ("D(CS), HA") supplemented that HA had provided some 300 000 additional episodic quota in GOPCs in 2012 to partially meet the non-urgent medical needs. Noting that there would be a surge in A&E service demand during weekends and public holidays when many private clinics were closed, a list of private doctors and clinics who/which would be in operation during weekends and public holidays would be published on the websites of HA and the Hong Kong Medical Association to facilitate access to private healthcare services by patients with episodic diseases. Publicity to encourage these patients to visit the 12 public GOPCs in operation during weekends and public holidays had also been enhanced. In addition, extra financial incentives had been provided to doctors who were willing to work extra service sessions for the A&E Departments (i.e. evening session during weekdays and morning, afternoon and evening sessions during Saturdays, Sundays and public holidays) through the special honorarium scheme. It was expected that with an improvement in public-private market balance and an increase in healthcare manpower in the longer term, the A&E services of HA could be further improved.

62. Dr Elizabeth QUAT cited the media reports and the cases she had handled to illustrate that it was not uncommon for patients to wait for a couple of hours at the A&E Department of the Prince of Wales Hospital ("PWH") before they could receive treatment. She sought clarification on how the average waiting time cited by USFH was calculated, and whether HA had set performance pledges on the waiting time for treatment of patients triaged as semi-urgent and non-urgent cases. Mr CHAN Han-pan expressed a similar concern, adding that to his understanding, there were cases whereby patients seeking the A&E services at Kwong Wah Hospital had to wait for 12 hours. Dr Helena WONG was concerned about the difference in the average waiting time for semi-urgent and non-urgent cases among different hospital clusters. For instance, in 2011, the average waiting time for semi-urgent cases was 52 minutes and 84 minutes for Hong Kong East Cluster and Kowloon East Cluster respectively; and the average waiting time for non-urgent cases was 60 minutes and 155 minutes for New Territories East Cluster and Kowloon East Cluster respectively.

63. D(CS), HA explained that 76 minutes and 103 minutes were the respective average waiting time for semi-urgent and non-urgent cases at A&E Departments. As regards the longest (90th percentile) waiting time for these cases, statistics of the last two months showed that patients might have to wait for three to four hours, or seven to eight hours in case the

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hospital concerned had to provide medical services and support for victims of disasters and major accidents. While HA had only set performance pledges on the waiting time for patients triaged as critical, emergency and urgent cases, it should be noted that nurses would monitor the conditions of all patients awaiting consultation and advance their priorities for treatment as and when necessary. D(CS), HA further said that arrangement had been made to flexibly deploy staff from other clusters to alleviate the work pressure of the A&E Department of PWH. It was anticipated that with the intake of the local medical graduates in July 2013, the manpower constraint of PWH would be relieved. Mr CHAN Han-pan pointed out that while there was a 9% increase in the number of attendances of the A&E Departments of HA in the past five years, the number of doctors for the A&E specialty had increased by 10% over the corresponding period. He doubted whether the long waiting time for A&E services was due to the shortage of manpower or mismanagement of HA. D(CS), HA explained that the continuously high demand and the wastage of medical manpower had resulted in long waiting time for A&E services.

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

65. Noting that a total of 115 doctors and 286 nurses had been recruited under the pilot scheme launched by HA in February 2013 to recruit additional medical and nursing staff to alleviate the work pressure in the A&E Departments, Mr CHAN Han-pan enquired about the work hours of these additional staff and their distribution among hospitals. D(CS), HA advised that these servicing staff would provide support for a four-hour service session to handle patients triaged as semi-urgent and non-urgent cases. The scheme had been piloted in seven hospitals since February 2013 and was planned to be expanded to another five more hospitals during the Easter holidays.

66. Mr CHAN Han-pan suggested that consideration could be given to recruiting doctors who were currently working in the private sector to work part-time in the A&E Departments. D(CS), HA advised that HA had been doing so. To date, the number of part-time doctors (including both leaving and retiring doctors) recruited to A&E specialty had doubled from 14 (as at 31 March 2011) to 28 (as at 31 December 2012). Holding the view that the number of part-timers was on the low side, Dr Helena WONG called on HA to improve the remuneration package so as to attract more retiring doctors to work part-time in the A&E Departments to ease the manpower shortage. In the longer term, consideration could be given to reviewing the retirement age of doctors working in HA. Mr CHAN Han-pan urged HA to

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enhance the part-time remuneration and benefits package to make it more attractive to the private doctors. D(CS), HA advised that HA had reviewed and refined the part-time employment package in 2012. At present, the part-time employment package was on a 70% pro-rata basis to the equivalent full-time package, as part-time doctors were not required to perform night duties. HA would continue to monitor closely the effectiveness of this measure.

67. Dr Joseph LEE asked whether consideration could be given to shortening the waiting time for admission to clinical specialties via the A&E Departments to alleviate the congestion of the A&E Departments, as well as establishing observation wards in all A&E Departments in order to improve the efficiency in handling acute patient admission. D(CS), HA responded that shortage of hospital beds and medical manpower were the main reasons for the long waiting time for admission via the A&E Departments. In the light of this, in addition to the human resources initiatives mentioned earlier, a total of 287 additional hospital beds would be opened in 2013-2014 to meet the increasing service demand. HA had also established Emergency Medicine Wards ("EMWs") in 10 acute hospitals in 2013. Patients could receive initial investigation and treatment in EMWs at night and be discharged or transferred to the medical ward on the following day.

Admin/HA

68. In view of the time constraint, Mr CHAN Han-pan and Dr Helena WONG requested HA to provide the following information after the meeting -

(a) a breakdown of the number of healthcare personnel in the A&E speciality by hospitals in the past five years;

(b) a breakdown of the average weekly work hours of the healthcare personnel in the A&E speciality by hospitals in the past five years;

(c) a breakdown of the establishment and the number of vacancies of the healthcare personnel in the A&E speciality by hospitals in the past five years;

(d) whether consideration could be given to providing 24-hour acute stroke thrombolytic services in all hospital clusters; and

(e) whether consideration could be given to providing A&E services in all districts.

D(CS), HA agreed.

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69. There being no other business, the meeting ended at 7:45 pm.

Council Business Division 2
Legislative Council Secretariat
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