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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 2012-2013 Legislative Council ("LegCo") session. It will be tabled at the Council meeting of 10 July 2013 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 19 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

Regulation of medical beauty treatments/procedures

4. Following widespread media coverage on an incident which had caused one death and serious sickness of three other patients after they had received medical beauty treatments ("the medical beauty incident"), the Panel held two special meetings to discuss the regulation of medical beauty treatments/procedures and received views from deputations on the

subject at one meeting. Members in general were of the view that the existing legislation in regulating the conduct of advanced therapies was far from effective in protecting public health. They noted with grave concern the performance of some high-risk and complicated medical treatments/procedures at ambulatory medical centres and non-clinical facilities, as well as the lack of regulation for laboratories set up in the community setting for processing health products for advanced therapies. Members urged the Administration to expeditiously review and introduce a comprehensive regulatory framework for those high-risk medical treatments/procedures performed outside the hospital setting. They also urged that in hammering out the regulatory framework for medical treatments/procedures, due regard should be given to ensuring the enforceability and practicability of the legislative provisions.

5. The scope of the regulation of medical beauty treatments/procedures was also of grave concern to members. Some members considered that an essential first step to regulate medical treatments/procedures was to provide a clear definition of "medical treatment/procedure". Some other members, however, took the view that the crux of the problem was the lack of regulation of the high-risk cosmetic procedures. The Administration should examine the need to introduce regulatory control over the beauty services companies.

6. The Panel passed a motion at the meeting on 26 October 2012, expressing serious disappointment that the Administration had failed to provide effective measures to ensure that the health and life of people receiving medical beauty therapy would not be threatened, and urging the Government to comprehensively review the medical beauty industry and expeditiously launch effective measures to safeguard the public, including introducing legislation and a licensing system to regulate the medical beauty industry.

7. According to the Administration, a Steering Committee on Review of the Regulation of Private Healthcare Facilities ("Steering Committee") was set up on 11 October 2012 to conduct a review on the regulatory regime for private healthcare facilities. Working groups would be established under the Steering Committee to assist its work. Following the medical beauty incident, the first working group to be set up under the Steering Committee would be tasked to differentiate between high-risk medical treatments and low-risk, non-invasive beauty services as well as formulate guidelines as interim measures pending the development of relevant legislative proposals. Meanwhile, the Department of Health ("DH") would step up its efforts in screening advertisements of beauty services and take enforcement actions against

beauty services companies suspected of involving in the provision of high-risk medical treatments/procedures to customers.

Elderly Health Care Voucher Pilot Scheme

8. The Panel was consulted on the proposed enhancements to the Elderly Health Care Voucher Pilot Scheme, which included increasing the voucher amount from $500 to $1,000 per year with effect from 1 January 2013; converting the voucher scheme from a pilot project into a recurrent support programme for the elderly; and allowing the unspent part of the vouchers to be carried forward and accumulated by an eligible elderly, subject to a ceiling of $3,000.

9. While welcoming the Administration's proposed enhancements to the voucher scheme, many members expressed disappointment at the Administration's proposal to maintain the eligible age for the voucher scheme at 70 or above. They called for the lowering of the eligible age to 60 or 65. Some members were of the view that the increase of voucher value from $500 to $1,000 per year was not sufficient to meet the medical needs of the elderly people. They urged the Administration to further increase the voucher value to $1,500 per year. Some other members did not consider that there was a need to impose a ceiling of $3,000 on the total cumulative value of unspent vouchers. They urged the Administration to remove the ceiling.

10. In the Administration's view, it would be prudent to continue to maintain the eligible age at 70 or above as the pilot scheme would be converted into a recurrent funding programme for the elderly. The imposition of a ceiling on the total cumulative value of the vouchers could also encourage the eligible elderly to make more frequent use of the vouchers for primary care services, instead of saving the vouchers for the management of acute episodic conditions. Taking into account members' views, the Administration would initiate a further review of the voucher scheme after accumulating experience on its operation.

11. Some members expressed concern on the low utilization rate of the health care vouchers and the low participation rate of healthcare service providers, in particular the Chinese medicine practitioners ("CMPs"), in the voucher scheme. They urged the Administration to streamline the registration process and provide technical support to medical service practitioners to encourage their participation in the scheme. They also stressed the need for the Administration to conduct a more in-depth assessment of the voucher scheme's effectiveness. According to the Administration, DH would launch a series of

promotional activities in early 2013 to further encourage the provision and utilization of primary care services. It would also explore ways to encourage more service providers, including CMPs, to participate in the voucher scheme.

Elderly Health Assessment Pilot Programme

12. The Panel received a briefing from the Administration on the Elderly Health Assessment Pilot Programme which aimed to provide health assessment via eligible non-governmental organizations ("NGOs") to about 10 000 elderly persons aged over 70 or above over a two-year pilot period. While members in general did not oppose the Pilot Programme as they considered it necessary to enhance the primary care services especially for elderly people, many members were of the view that the justification for the introduction of the Pilot Programme was weak. In their view, the services to be provided by the Pilot Programme were more or less the same as those by the Elderly Health Centres ("EHCs") and hence, more resources should be allocated to EHCs to meet the needs of elderly persons who were on the waiting list of EHCs. These members queried the need to launch a separate programme with similar services of EHCs on a trial basis.

13. Some members were of the view that the eligible age of elderly persons for receiving services under the Pilot Programme should be lowered from 70 to 65 as elderly persons aged 65 years or above could be enrolled in EHCs. They also considered that the coverage of the Pilot Programme, which was targeted at serving 10 000 elderly persons aged 70 years or above, was too small. They were of the view that all elderly persons aged 70 years or above should be eligible for receiving subsidized health assessment services in the longer term.

14. According to the Administration, while both the Pilot Programme and EHCs provided similar health assessment services, the selected NGOs for the Pilot Programme were required to provide health assessment services based on a protocol developed in accordance with the Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings ("the Reference Framework"). The Reference Framework was developed in accordance with the primary care development strategy promulgated by the Administration in December 2010. In the Administration's view, subsidizing elderly persons to receive protocol-based health assessment services provided by NGOs would widen the choice of preventive care for the elderly and promote the use of community-based private primary care services.

15. Members remained sceptical about the cost effectiveness of the Pilot Programme and requested the Administration to revert to the Panel one year after the launch of the Pilot Programme on a review of its effectiveness.

Mental health policy and service programmes

16. The Panel continued to follow up on the subject of mental health policy and services. Members were advised that the Administration planned to establish a committee to review the existing mental health service provision with a view to promoting mental health and strengthening support for persons with mental problems. Members generally welcomed the establishment of the review committee. Some members expressed concern about the composition of the review committee. They urged that the review committee should comprise representatives of all the stakeholders with a common goal of delivering better mental health services. Some other members considered that the first and foremost task of the Administration should be to develop a comprehensive mental health policy addressing issues such as healthcare manpower as well as mental health service development and accommodation. They also stressed the need to enhance public education in order to raise public awareness of mental health and foster positive attitude in the community towards mental patients.

17. Some members expressed concern about the inadequate community support services for discharged mental patients and their families and carers. They urged the Administration to allocate resources to strengthen the healthcare manpower to enhance community support for mental patients. They also urged the Administration to consider providing evening specialist outpatient services for mental patients. Some other members considered the existing hospital environment neither supportive nor friendly for mental patients. They urged the Administration to carry out improvement works to the physical conditions of the psychiatric hospitals. Members also called on the Hospital Authority ("HA") to use more new psychiatric drugs with proven effectiveness and fewer side effects to improve treatment outcome.

18. The Administration assured members that the review committee would study the existing policy on mental health with a view to mapping out the future direction for development of mental health services in Hong Kong. It would also consider means and measures to strengthen the provision of mental health services. At the request of the Panel, the Administration undertook to revert to the Panel on the outcome of the review.

Development of Chinese medicine

19. Members were briefed on the work of the Administration for the development of Chinese medicine in Hong Kong. Members were generally of the view that more resources should be allocated to develop Chinese medicine. They also stressed that the Administration should clearly define the role of CMPs in the provision of public healthcare services, assist listed CMPs in meeting the registration requirements and further integrate the Chinese and Western medicine in the public healthcare system. Some members expressed dissatisfaction with the lack of clinical training grounds in the local hospital setting for Chinese medicine students and the limited employment opportunities for local Chinese medicine graduates. They stressed the need to establish a Chinese medicine hospital in Hong Kong.

20. According to the Administration, there had been increasing interface between Chinese and Western medicine in public hospitals in recent years. More than 20 public hospitals had provided Chinese and Western medicine shared care services for the treatment of specific illnesses. A Chinese Medicine Development Committee ("CMDC") was also established by the Government in January 2013 to study the policies and measures to further the development of Chinese medicine and to make recommendations to the Government. CMDC would also explore the feasibility of establishing Chinese medicine hospitals in Hong Kong.

21. Some members expressed strong dissatisfaction with the non-inclusion of Chinese medicine in the scope of medical benefits for civil service eligible persons. They urged the Administration to review the policy. They also expressed concern that the Chinese medicine manufacturing sector, in particular the small and medium enterprises, lacked the factory premises, personnel and expertise to support the future implementation of the mandatory Good Manufacturing Practice ("GMP") for manufacture of proprietary Chinese medicine ("pCm"). They urged the Administration to consider providing financial assistance to local pCm manufacturers to facilitate their compliance with the GMP requirements. Some members expressed concern about the requirement that existing licensed Chinese medicine traders who were conducting their business on domestic premises had to relocate to suitable premises by 31 December 2013 to continue their business. Pointing out that there had not been any consultation with the trade on the above requirement, these members urged that the requirement should be shelved.

22. According to the Administration, the purpose of introducing GMP to pCm manufacturing was to promote the standardization of the pCm manufacturing industry and enhance the standard of the trade to assure the quality and safety of pCm. It was also in line with international trends and requirements for manufacturing medicinal products. As regards the inclusion of Chinese medicine in the scope of medical benefits for civil service eligible persons, members were advised that the scope of medical benefits for civil service eligible persons was defined as those medical services provided by DH or HA. DH did not operate any Chinese medicine clinics ("CMCs") and the services provided by CMCs were not part of the standard service of HA. That said, the Administration assured members that CMDC would examine the role of Chinese medicine in the public healthcare system and the Civil Service Bureau would take into account the views of CMDC when considering the scope of civil service medical benefits in the future.

23. Some members expressed concern about the composition of CMDC. They were of the view that CMPs were under-represented in CMDC and CMPs' views were not awarded sufficient consideration in CMDC. These members were also dissatisfied that CMDC had no representative from members of the public. According to the Administration, CMDC was chaired by the Secretary for Food and Health and comprised representatives of all the stakeholders including CMPs, the Chinese medicine trade, academia, research institutes, healthcare sectors and lay persons. The appointment of members from other healthcare sectors such as Western medicine practitioners was necessary in order to facilitate the integration of Chinese and Western medicine in the public healthcare system.

Promotion of breastfeeding

24. In the course of the discussion of the regulation of formula products and foods for infants and young children, members expressed unanimous support for the promotion of breastfeeding. They criticized the Administration for not providing adequate support for promoting breastfeeding and assisting mothers in sustaining breastfeeding. They urged the Administration to allocate more resources to create a breastfeeding-friendly environment in the community, such as providing babycare rooms in public places, strengthening public education and providing more assistance to new mothers for breastfeeding.

25. Members were also briefed on the progress of the development of the Hong Kong Code of Marketing and Quality of Formula Milk and Related Products, and Food Products for Infants and Young Children

("the Hong Kong Code"). The Hong Kong Code was voluntary in nature, aiming at protecting breastfeeding and ensuring the proper use of formula milk and related products for infants and young children up to the age of 36 months. Some members expressed disappointment at the absence of legislative proposals to regulate the marketing and claims of formula milk products. They urged the Administration to expeditiously introduce legislation instead of a voluntary Hong Kong Code to regulate the marketing and claims of formula milk products.

Strategy and measures in prevention and control of influenza

Seasonal influenza

26. The Panel received a briefing from the Administration on its additional preventive measures and enhanced healthcare support, to prepare for the winter influenza season of 2012-2013. Members noted that an annual Government Vaccination Programme ("GVP") was in place to provide free seasonal flu vaccines to target groups (i.e. at-risk and/or under-privileged), which included, among others, children between the age of six months and less than six years from families receiving Comprehensive Social Security Assistance ("CSSA"). Some members were of the view that the target groups of GVP should follow the advice of the Centers for Disease Control and Prevention of the United States which recommended that all persons aged six months and above who did not have contraindications to vaccination should be vaccinated annually to prevent influenza virus infection and its complications. These members urged that all primary school students, i.e. children between the age of six and 12 years, as well as those aged between 50 and 64 years, should be included into the target groups for influenza vaccination.

27. The Administration advised that the Scientific Committee on Vaccine Preventable Diseases of the Centre for Health Protection would recommend each year the target groups to receive seasonal influenza based on a range of scientific considerations taking into account local disease burden and international experience. There was evidence showing that children aged six years or above were less prone to influenza-associated hospitalizations than children aged five years or below. In view of finite public resources, the Administration considered it more appropriate for GVP to cover high-risk persons who were facing financial difficulties.

Human Influenza A (H7N9) and Severe respiratory diseases associated with novel coronavirus

28. The Panel was briefed on the Administration's measures for the prevention and control of Severe Respiratory Disease associated with Novel Coronavirus ("SRD-NCoV") and Influenza A (H7N9). Members stressed that the issue of timely alerts and orderly dissemination of credible information on the latest situation of the disease were of paramount importance for the various sectors of the community to take precautionary and control measures. Any time lapse between the patient's disease onset and notification on confirmed human infection cases might undermine the effectiveness of the prevention and control measures implemented. Members urged the Administration to strengthen the communication and response network with the relevant health authorities outside Hong Kong as well as step up its efforts in keeping the public informed of the latest influenza situation in Hong Kong and other parts of the world.

29. The Administration assured members that it had all along been maintaining close communication and co-operation with the relevant authorities, in particular the Mainland health authorities, and the World Health Organization ("WHO") to ensure expeditious and effective exchange of important information about infectious disease outbreaks.

30. While noting that the overall risk of an avian influenza outbreak in Hong Kong was relatively low, members were still deeply concerned about the preparedness of the Government in case of an influenza pandemic. In particular, they were concerned whether there would be adequate supply of masks and antiviral drugs to deal with an influenza pandemic. According to the Administration, regular exercises and drills had been conducted to test and enhance the emergency preparedness of Government departments in case of public health emergencies. Arrangements had also been made to stock up sufficient supply of surgical masks for frontline healthcare workers as well as antiviral drugs such as Tamiflu to prepare for emergency situations. In addition, the Administration had implemented a series of prevention and control measures, including enhanced surveillance of sick travellers, referral of suspected cases to public hospitals for further investigation and regular updates for travellers, to safeguard Hong Kong against any communicable diseases. HA had also improved its facilities by adding 1 400 isolation beds.

31. Members were generally supportive of the implementation of enhanced surveillance of arriving travellers, particularly those coming from places of infection. There was a suggestion that these travellers should be asked to fill in health declaration forms at the border control points to facilitate early identification of and timely responses to public health emergencies. The Administration, however, was of the view that conducting temperature screening at entry points would be more effective to identify suspected cases. DH would continue to monitor and follow up relevant recommendations on port health measures made by WHO and would further step up control measures as appropriate.

Development of public hospitals

Development of a Centre of Excellence in Paediatrics

32. The Panel was consulted on the funding proposal for the establishment of the Centre of Excellence in Paediatrics ("CEP") which aimed to enhance the quality of paediatric services in Hong Kong. Noting that training and research would also be a component of CEP to promote and advance research in relation to paediatrics, some members expressed concern about the possible duplication of functions between CEP and the teaching hospitals. Some other members queried the feasibility and effectiveness of the referral system of patients to CEP, in particular from other public hospitals with paediatric departments. They expressed worry that public hospitals with paediatric departments might be reluctant to refer complex cases to CEP as this might affect their future allocation of resources from HA. These members stressed the need for a clear set of referral guidelines and urged the Administration to define clearly the roles of CEP and public hospitals with paediatric departments in the provision of paediatric services.

33. According to the Administration, the roles and partnership between CEP and public hospitals had been clearly defined. CEP would mainly provide tertiary specialist services for children under the age of 18 with serious and complex illnesses while public hospitals with paediatric departments would continue to provide acute paediatric services, secondary care services and community care in their respective communities. There was also no requirement for the referring doctors to withdraw from the patients' care after referring the patients to CEP. The Administration further assured members that the local universities with medical schools would continue to have an important role in clinical research and training of healthcare professionals. HA would work closely with the paediatrician community to develop referral guidelines, common clinical protocols and practical shared care model.

34. Some members expressed concern about the workload of CEP. In the light of the large number of children born locally to Mainland parents in recent years, they urged the Administration to carry out an assessment of the impact of these children on the future demand for paediatric services in Hong Kong. There was also concern about the further pressure on local healthcare manpower with the establishment of CEP.

35. According to the Administration, babies born to Mainland women in Hong Kong were Hong Kong residents and were entitled to use subvented public healthcare services at HA's hospitals, including CEP. HA had also taken into account the demand for paediatric services for these newborn babies when planning for the services of CEP. The service capacity of CEP would be sufficient to meet the demand for tertiary paediatric services in future.

36. As regards the supply of healthcare manpower, members were advised that the Government had set up the Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development to conduct a strategic review on healthcare manpower planning and professional development in Hong Kong. The Steering Committee would formulate recommendations on how to cope with the anticipated demand for healthcare manpower, strengthen professional training and facilitate professional development.

Commissioning of the North Lantau Hospital, phase I

37. The Panel received a briefing from the Administration on the commissioning of the North Lantau Hospital ("NLH") in phases starting from September 2013. Members noted that upon commissioning of NLH in September 2013, only daytime Accident and Emergency ("A&E") services would be provided. Members were generally dissatisfied with the proposed service hours of the A&E services. They urged HA to extend the service hours of the A&E department of NLH as soon as practicable and implement measures during the interim to meet the needs of the residents of Tung Chung and its vicinity. Members were also deeply concerned about the adequate supply of healthcare manpower at NLH upon its commissioning in September 2013.

38. Members were advised that eight-hour A&E services would initially be provided in September 2013, with a view to extending the service hours to 16 hours, and further to 24 hours within six to 12 month's time subject to manpower availability. Meanwhile, the General

Outpatient Clinic ("GOPC") provided by HA in the Tung Chung Health Centre would be relocated to NLH in September 2013. The service hours of GOPC would be from 9:00 am to 11:45 pm. Under the existing cluster arrangement, hospitals under the Kowloon West Cluster, leading by Princess Margaret Hospital, would provide support to the services of NLH. While some service areas such as A&E were still be critically short of medical staff and the situation might be likely to continue for a couple of years, members were assured that HA had already allocated additional resources to implement a series of measures to recruit and retain healthcare staff. Upon commissioning of NLH, HA would arrange for suitable and adequate healthcare manpower to launch the services of NLH.

Public hospital services

Provision of obstetric services in Tseung Kwan O Hospital

39. The Panel continued to follow up on the provision of obstetric services in Tseung Kwan O ("TKO") Hospital. Many members expressed dissatisfaction that HA had failed to honour its commitment to providing sufficient manpower for commissioning obstetric and Neonatal Intensive Care Unit services in TKO Hospital in 2013. While noting that there was currently a shortfall of healthcare personnel in HA, members opined that the Administration should at the very least commit a timetable for the opening of delivery services at TKO Hospital. Pointing out that the long travelling time from TKO to United Christian Hospital might adversely affect the conditions of the expectant mothers who were in urgent need or about to give birth, members called on the Administration to look squarely the need of the these women.

40. The Administration explained that the timing for the provision of the delivery and NICU services in TKO Hospital hinged on factors such as the overall service demand, the supply of healthcare personnel and the overall allocation of healthcare resources. When considering the timeline for the provision of the delivery services in TKO Hospital, the Administration would take heed of the views of TKO residents in this regard.

Accident and emergency services of public hospitals

41. Members were deeply concerned about the A&E services of public hospitals. Members noted that under the patient triage measures implemented in the A&E departments, patients were classified into five categories based on their clinical conditions: critical, emergency, urgent,

semi-urgent and non-urgent. While HA was able to meet the performance pledges to provide services to patients classified in critical, emergency or urgent conditions, members noted with grave concern the waiting time for semi-urgent and non-urgent cases, which were 76 minutes and 103 minutes respectively. They urged the Administration to implement effective measures to reduce the waiting time for the semi-urgent and non-urgent cases. Some members also called on HA to improve the remuneration package of doctors and nurses so as to attract more doctors and nurses to work in the A&E Departments to ease the manpower shortage. There was also a suggestion of extending the service hours of GOPCs to handle semi-urgent and non-urgent cases.

42. According to the Administration, patients with pressing medical needs were able to receive timely medical treatment under the triage system. At present, HA operated 74 GOPCs, of which 23 provided evening out-patient services until 10:00 pm. Members were advised that to further extend the services of GOPCs into the small hours or provide overnight services would create greater pressure on healthcare staffing. HA had implemented various measures to increase manpower, including providing financial incentives to doctors working extra service sessions for the A&E Departments, appointing part-time doctors and recruiting non-local doctors under limited registration for the A&E Departments. HA had since February 2013 implemented a pilot scheme to recruit additional medical and nursing staff to alleviate the work pressure in the A&E Departments. HA would continue to monitor closely the service demand in the A&E Departments and the effectiveness of the measures implemented.

Private hospital development

43. Members were briefed by the Administration on the tender result for the development of private hospitals at two reserved sites at Wong Chuk Hang and Tai Po respectively. Members noted that the tender for the site at Wong Chuk Hang was awarded to GHK Hospital Limited while the tender for the site at Tai Po was cancelled since the only tender submission received for the site failed to meet the mandatory requirements as set out in the tender documents.

44. In view of the tender results, members were concerned about the future development of private hospitals. Some members considered that the site at Tai Po could be used for the development of public hospitals. The Administration might need to identify other suitable sites for private hospital development. They also stressed that the site at Tai Po and the

other two reserved sites not yet put out for tender should be used for healthcare purpose only and should not be changed to other purposes such as housing.

45. Members were advised that the Administration would first consider proposals for service expansion of existing private hospitals, which would bring about a substantial increase in the number of private hospital beds in a few years' time. The Administration would also consider the estimated need for private hospital services, the implementation of the Health Protection Scheme ("HPS") and the market situation before deciding on the use of the remaining three sites for private hospital development.

46. Some members were of the view that any effort to boost non-local demand for medical services without a concurrent increase in the overall capacity of the healthcare system would only make the private services less affordable to the middle class. In their view, the Administration should first address the local demand for private healthcare services. Some other members called on the Administration to increase the number of private hospital beds and the supply of land for private hospital development. This would in turn lower the hospital charges to a more reasonable level as well as reduce the waiting time for surgeries.

47. The Administration stressed that at present, it would focus its efforts on enhancing the overall service capacity of the healthcare system, increasing the healthcare manpower and meeting the local demand. It was also important to promote the demand for private healthcare services from clienteles outside Hong Kong in the longer term, so as to ensure the financial sustainability of these services.

Regulation of private hospitals

48. The Panel continued to follow up the subject of regulation of private hospitals. Some members expressed grave concern about the charitable status of private hospitals. Noting that some tax-exempt private hospitals had derived hefty profits from their hospital operations and hence, deviated from their charitable objects, these members questioned if the tax exemption status of those private hospitals should be revoked. There was a view that different sets of land grant conditions should be imposed on profit-marking and non-profit-making private hospitals. Members also called on DH to make public information on those private hospitals which were required to provide free or low-charge beds under their land grants for reference by the public and patients.

Consideration should also be given to putting in place a mechanism to ensure the provision of reasonably priced private hospital services to enable more people who could afford to use private hospitals services on a sustained basis, so as to address the imbalance between the public and private healthcare services.

49. According to the Administration, DH and the Lands Department were following up the issue on whether certain hospitals had fully complied with the relevant land grant conditions. The Administration assured members that a mechanism would be put in place in the future to eradicate the risk of hospitals' surplus being diverted from ploughing back for the hospitals' use.

50. Members also expressed deep concern about the unreasonably high level of charges of the existing private hospitals which, in their view, ran contrary to the public interest. They urged the Administration to enhance transparency of charges of private hospitals to safeguard patients' interests. Some members suggested that the Administration should encourage doctors to reach an understanding with individual patients on the medical costs involved before the performance of treatments and procedures. Some other members suggested that consideration could be given to requiring private hospitals operating on lands granted at nil or nominal premium to introduce separate pricing for Hong Kong residents and non-Hong Kong residents.

51. The Administration responded that it had no intention of regulating the level of charges of private hospitals. It was also not appropriate for the Administration to regulate the level of charges of profit-making hospitals developed on land acquired through land sale under the free market principle. Nevertheless, the Administration stressed that it would endeavour to enhance price transparency to facilitate access to more personalized private healthcare services by those who were able and willing to use private healthcare services. Members were advised that a set of special requirements covering various aspects such as packaged charging, price transparency and service standard had been included in the tender documents for two reserved sites at Wong Chuk Hang and Tai Po for development of new private hospitals.

Review of fees and charges for private patients and non-eligible persons in the Hospital Authority

52. The Panel received a briefing from the Administration on its review of fees and charges for private patients and non-eligible persons ("NEPs") in HA. Members noted that the principle of setting charges for NEPs was on a cost recovery basis and the fees for private patients would be set on the higher of cost or market price for the respective services. Noting with concern that HA's last major revision on the fees and charges for these patients was conducted about a decade ago, members were of the view that the Administration should conduct the review on a more frequent and regular basis, say every two to three years, to recover cost increases in a timely fashion. Some other members expressed concern that vulnerable NEPs suffering from infectious diseases of public health significance might be reluctant to be hospitalized after seeking consultation in view of the high cost incurred, and hence posed risk to public health. There was also a view that the increase in the fees and charges for NEPs might further aggregate the problem of default payments from NEPs. Some members suggested that HA should work with the Immigration Department to consider imposing penalties on NEPs with outstanding fees who re-entered Hong Kong. In addition, overseas students studying in Hong Kong should be required to take out medical and hospitalization insurance policy to cover the possible related cost incurred during their stay in Hong Kong. The Administration assured members that HA had already put in place a series of measures to minimize default and it might also take legal actions to recover default payments from NEPs where appropriate.

53. Many members were of the view that Mainland spouses of Hong Kong residents seeking public healthcare services should not be charged the NEP rates. However, the Administration insisted that the classification of NEPs should be based on the status of the patients receiving the services and no consideration would be given to family relationship. While the Administration fully understood members' concern, it had been the Government's well-established policy that the heavily subsidized public healthcare services should only be made available to Hong Kong residents but not their non-local spouses to ensure rational use of the finite public resources. That said, the Administration supplemented that Hong Kong residents' Mainland spouses who entered Hong Kong for settlement on the strength of an One Way Permit would be regarded as eligible persons when seeking public healthcare services, albeit that they had not acquired the permanent resident status. There was also a medical fee waiver mechanism to assist those patients who were in financial need.

54. Members maintained the view that the Administration should revise its policy to allow Mainland spouses of Hong Kong residents to access public healthcare services at subsidized rates. The Panel passed a motion at the meeting on 17 December 2012, urging the Government to accord Mainland spouses of Hong Kong residents equal status with Hong Kong residents and abolish all discriminatory charging policies.

Regulation of healthcare intermediary service

55. Members expressed dissatisfaction with the lack of regulation for the healthcare intermediary service. They were gravely concerned that the commercial interests and drive to contain costs among the healthcare intermediary service providers might induce the healthcare service providers to compromise their professional autonomy in the treatment of patients. The Panel passed a motion at its meeting on 20 May 2013, urging the Government to immediately study regulating healthcare intermediaries by legislation, so as to protect the healthcare rights of patients.

56. According to the Administration, doctors were under obligation to ensure that their medical services were up to the professional standards stipulated by the Medical Council of Hong Kong in the Code of Professional Conduct for the Guidance of Registered Medical Practitioners. This obligation would not be affected by the payment arrangement between the doctors and the patients or who paid or settled the fees for the patients. Meanwhile, a Steering Committee on Review of the Regulation of Private Healthcare Facilities was established in October 2012 to review the regulatory regime for private healthcare facilities. According to the Administration, the review would also cover issues relating to healthcare intermediary schemes.

Health Protection Scheme

57. The Panel continued to follow up the voluntary 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. The Panel in the Fourth Legislative Council appointed on 8 August 2011 a Subcommittee on HPS ("the former Subcommittee") to study issues relating to HPS. The former Subcommittee submitted its report to the Panel on 4 July 2012 and recommended that the Panel should appoint a subcommittee to assist its monitoring work of the implementation progress of HPS in the Fifth

Legislative Council. In the light of the above, the Panel agreed at its meeting on 19 November 2012 to appoint a subcommittee to study issues relating to HPS.

58. Since the commencement of its work in November 2012, the Subcommittee had held five meetings to discuss with the Administration on various issues of concern. These included the roles of public and private healthcare systems, roles of public funding including the utilization of government subsidy, the manpower requirement and design and the regulatory framework of HPS. The Subcommittee would continue its work in the 2013-2014 session.

Long-term care policy

59. The long term care policy was of grave concern to members. In view of the ageing population, members considered that the Panel should address the imminent needs of monitoring the Government's long-term care policies and services for the elderly, persons with disabilities and persons with chronic diseases. As the long-term care policy and services straddled welfare and health policies, a Joint Subcommittee was formed under the Panel and the Panel on Welfare Services on 19 November 2012 to study the long-term care policy and services.

60. Since the commencement of its work in November 2012, the Joint Subcommittee had held eight meetings to discuss with the Administration on various issues of concern. These included the policies and planning for provision of residential care services; planning for the provision of home care, community care and residential services for people with disabilities and the elderly; support and allowance for carers; care services for people with dementia; ageing of special groups such as mentally handicapped person; review of Community Care Service Voucher for the Elderly; review of the discharge support programme for the elderly; mental health case management; financial assistance on medications and medical/rehabilitation appliances; and guardianship system for mentally incapacitated persons. The Joint Subcommittee would continue its work in the 2013-2014 session.

Other issues discussed

61. The Panel also examined in detail the Administration's proposals on the construction of Tin Shui Wai Hospital, ward renovation in Kwai Chung Hospital, and the reprovisioning of Yaumatei Specialist Clinic at Queen Elizabeth Hospital. Other issues discussed by the Panel included the waiting time management for specialist outpatient clinics, dental care

policy and services for the elderly, and a proposal to extend two supernumerary Directorate Posts for the implementation of the Electronic Health Record Programme.

Meetings held

62. During the period between October 2012 and June 2013, the Panel held a total of 15 meetings, including one joint meeting with the Panel on Food Safety and Environmental Hygiene. Another meeting has been scheduled for July 2013.

Council Business Division 2
Legislative Council Secretariat
4 July 2013

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 2012-2013 session

Chairman	Dr Hon LEUNG Ka-lau
Deputy Chairman	Dr Hon Joseph LEE Kok-long, SBS, JP
Members	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, SBS, JP Hon CHEUNG Kwok-che Hon Mrs Regina IP LAU Suk-yee, GBS, 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 (Total : 19 members)
Clerk	Ms Elyssa WONG
Legal adviser	Ms Wendy KAN
Date	2 July 2013