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Legislative Council

LC Paper No. CB(2)1607/13-14
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Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 17 February 2014, at 4:30 pm
in Conference Room 3 of the Legislative Council Complex

Members present : Dr Hon LEUNG Ka-lau (Chairman)
Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN (Deputy Chairman)
Hon Albert HO Chun-yan
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
Hon POON Siu-ping, BBS, MH
Dr Hon CHIANG Lai-wan, JP

Members attending : Hon WONG Kwok-hing, BBS, MH
Hon WU Chi-wai, MH
Dr Hon Kenneth CHAN Ka-lok
Hon KWOK Wai-keung
Hon Tony TSE Wai-chuen

Members absent : Hon Vincent FANG Kang, SBS, JP
Dr Hon Helena WONG Pik-wan
Dr Hon Elizabeth QUAT, JP

Public Officers attending : Items III and IV

Professor Sophia CHAN Siu-chee, JP
Under Secretary for Food and Health

Dr CHEUNG Wai-lun
Director (Cluster Services)
Hospital Authority

Item III

Ms Angela LEE
Principal Assistant Secretary for Food and Health (Health) 2

Dr Libby LEE
Deputising Director (Strategy & Planning)
Hospital Authority

Dr C C LUK
Cluster Chief Executive, Hong Kong West Cluster
Hospital Authority

Mr Donald LI
Chief Manager (Capital Planning)
Hospital Authority

Item IV

Mr Davey CHUNG
Deputy Secretary for Food and Health (Health) 2

Dr K M CHOY
Chief Manager (Service Transformation)
Hospital Authority

Clerk in attendance : Ms Maisie LAM
Chief Council Secretary (2) 5

Staff in attendance : Ms Mina CHAN
Senior Council Secretary (2) 5

Ms Priscilla LAU
Council Secretary (2) 5

Ms Michelle LEE
Legislative Assistant (2) 5

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I. Information paper(s) issued since the last meeting
[LC Paper No. CB(2)764/13-14(01)]

Members noted that a referral from the meeting between Legislative Council ("LegCo") Members and Wong Tai Sin District Council members on 5 December 2013 regarding the provision of public outpatient and accident and emergency services in Wong Tai Sin District had been issued since the last meeting.

II. Items for discussion at the next meeting
[LC Paper Nos. CB(2)849/13-14(01) and (02)]

2. Members agreed to discuss the following items at the next regular meeting scheduled for 17 March 2014 at 4:30 pm -

(a) Drug Formulary of the Hospital Authority ("HA") and the Samaritan Fund; and

(b) Development of Chinese medicine and Integrated Chinese-Western Medicine Project.

III. Redevelopment of Queen Mary Hospital (Phase 1) - Preparatory works
[LC Paper Nos. CB(2)849/13-14(03) and (04)]

3. The Chairman reminded members that in accordance with Rule 83A of the Rules of Procedures, they should disclose the nature of any direct or indirect pecuniary interests relating to this funding proposal before they spoke on the subject.

4. Under Secretary for Food and Health ("USFH") briefed members on the proposed preparatory works for phase 1 redevelopment of Queen Mary Hospital ("QMH"), details of which were set out in the Administration's paper (LC Paper No. CB(2)849/13-14(03)).

5. Members noted the information note entitled "Redevelopment of Queen Mary Hospital" (LC Paper No. CB(2)849/13-14(04)) prepared by the LegCo Secretariat.

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Project implementation

6. Mr WONG Kwok-hing expressed support for the redevelopment of QMH. Noting that it would take around nine years (i.e. from 2014 to 2023) for the whole phase 1 redevelopment project ("the Project") to complete, he asked whether the Administration could speed up the preparatory works so as to advance the completion of the Project. Dr Kenneth CHAN urged early implementation of the Project. Expressing support for the redevelopment of QMH given its insufficient clinical space, unsatisfactory services zoning and outdated facilities, Mrs Regina IP considered that the Administration should expedite the implementation of the Project. Mr KWOK Wai-keung said that he welcomed the redevelopment of QMH. He sought clarification as to whether the construction of the proposed new hospital block was part and parcel of the Project.

7. USFH explained that the Project would be carried out in two stages, namely, preparatory works and main works. The preparatory works covered, among others, site investigations and conversion of the Senior Staff Quarters into clinical pathology laboratories, staff accommodation and teaching facilities for the temporary decanting of the existing facilities and equipment in the three buildings to be demolished (i.e. the Clinical Pathology Block, the University Pathology Building and the Housemen Quarters), and alternations to Block K to accommodate Haematology Department relocated from the Clinical Pathology Block and a new temporary body store. The main works, which included demolition of the three buildings and construction of the proposed new hospital block, would be proceeded with after the completion of the preparatory works. It was expected that the preparatory works would take around 40 months and would be completed by 2017. She assured members that the Administration would endeavour to facilitate an early completion of the preparatory works as far as practicable.

8. Mr Albert HO was of the view that the Administration should demolish the Senior Staff Quarters, the original design of which was not targeted for the provision of hospital services, for the construction of another new hospital block. Director (Cluster Services), HA ("D(CS), HA") explained that the proposed new hospital block to be constructed at the north end of the campus at the main works stage would accommodate a number of clinical departments of QMH as set out in paragraph 13(d) of the Administration's paper. Given that the Senior Staff Quarters, which was located at the south end of the hospital campus, was far away from the proposed new hospital block, it was considered inappropriate to make use of the site for the provision of clinical services. Hence, the Senior Staff Quarters would be used for temporary decanting arrangements to facilitate the carrying out of the main works.

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9. While welcoming the redevelopment of QMH, Mr POON Siu-ping expressed concern that there had been cases of defects, such as water seepage, in newly redeveloped public hospitals the construction works of which were tendered out. He urged the Administration to ensure the works quality of the Project. Chief Manager (Capital Planning), HA ("CM(CP), HA") advised that under the established mechanism, HA would conduct on-site inspections to check whether there had been any non-compliance with the requirements on works quality upon completion of individual project. Contractors had contractual responsibility to rectify the defects so identified.

Scope of the Project

10. Miss Alice MAK asked whether the clinical services of QMH would be disrupted by the redevelopment works. Mrs Regina IP raised a similar question, adding that there was a need to ensure that the redevelopment works would not affect the provision of professional clinical training by QMH. Mr POON Siu-ping expressed particular concern about the impact of the Project on the accident and emergency ("A&E") services of QMH.

11. USFH advised that the planning and design of the Project had already taken into account of the need to minimize disruptions to clinical services of QMH during redevelopment. The inpatient and other clinical services of QMH, including the A&E services, would not be affected by the proposed preparatory works of the Project. USFH added that HA would maintain close communication with the Li Ka Shing Faculty of Medicine of The University of Hong Kong to ensure that the Project would cause minimal disruption to QMH's provision of clinical training.

12. Noting that the clinical pathology laboratories would be temporarily housed in the Senior Staff Quarters and the Haematology Department would be relocated to Block K, the Chairman expressed concern about the delivery of blood specimens between the two buildings. CCE/HKWC, HA advised that there was no cause for such concern, as the distance between the two buildings was just about 200 metres and a link bridge would be constructed to connect the Senior Staff Quarters with other parts of the hospital campus.

13. Mr POON Siu-ping asked whether the decanting of the Clinical Pathology Block, the University Pathology Building and the Housemen Quarters to the Senior Staff Quarters would reduce their scale of operation. Replying in the negative, CM(CP), HA advised that the new construction was about five times the total floor area of the three existing buildings. In response to Mrs Regina IP's enquiry as to whether the preparatory works would affect the residents of the Housemen Quarters and the Senior Staff Quarters, Cluster Chief Executive, Hong Kong West Cluster, HA

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("CCE/HKWC, HA") advised that the Housemen Quarters were currently used for housing staff amenities and offices whereas the Senior Staff Quarters had already been vacated.

14. In response to Mr Albert HO's enquiry as to whether the construction of the new hospital block would provide additional space for QMH, USFH replied in the positive. She added that the redevelopment plan would also provide large floor plate to facilitate proper services zoning for easy co-location and patient-centred orientation.

15. Dr Fernando CHEUNG said that he was supportive of the Project, which in his view should have been carried out a long time ago. Expressing concern about the impact of the redevelopment works on barrier-free access in QMH, he considered that clear signage should be provided to facilitate the travelling of people with disabilities within the hospital during redevelopment. USFH assured members that HA would do so where necessary.

16. Mr KWOK Wai-keung enquired whether there would be an increase in the number of operating theatres in the redeveloped QMH. USFH advised that 24 additional operating theatres would be provided in the Peri-operative Centre to be set up in the proposed new hospital block.

Accessibility to QMH

17. Dr Kenneth CHAN asked whether and, if so, how the Administration would address the traffic congestion problem along the single access road to QMH during the carrying out of the preparatory works. USFH advised that the preparatory works, which involved mainly the conversion of the Senior Staff Quarters into clinical pathology laboratories, staff accommodation and teaching facilities, would not result in a significant increase in pedestrian or traffic flow in the vicinities. Works to improve the access road adjacent to the Administration Building leading to the site of the Senior Staff Quarters would also be conducted at the preparatory works stage.

18. Mr KWOK Wai-keung noted that at present, the A&E Department of QMH could only be accessed through a single, narrow two-lane road. He asked whether the relocation of the Department to the proposed new hospital block would enhance its accessibility. CM(CP), HA advised that there would be a second vehicular access route to QMH from Pokfulam Road via a ramp through the lower levels of the proposed new hospital block, in order to bring ambulances to a podium where the future A&E Department would be housed. In response to Mr KWOK Wai-keung's further enquiry as to whether the provision of the new access point from Pokfulam Road to enhance the

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accessibility to QMH was covered under the Project, CM(CP), HA replied in the positive.

19. Mr WONG Kwok-hing asked whether the Food and Health Bureau could explore with the Transport and Housing Bureau on the feasibility to include a QMH Station in the South Island Line (West) to tie in with the completion of the Project in 2023. Miss Alice MAK raised a similar question. CM(CP), HA responded that HA would follow up members' suggestion with the Mass Transit Railway Corporation Limited.

Project estimates

20. Dr Kenneth CHAN said that to his understanding, an earlier estimation of the Administration was that the redevelopment of QMH would cost around $7 billion. Expressing concern about the sustained escalation in construction cost in recent years, he enquired about the latest estimated cost for the Project. Mr POON Siu-ping raised a similar question. USFH advised that the estimated cost for the proposed preparatory works was in the order of $1.6 billion in money-of-the-day prices. The current estimation of HA was that the main works, which were planned to commence in 2017 for completion in 2023, would cost more than $8 billion.

Future redevelopment plan

21. Miss Alice MAK asked whether the Project would provide additional space for future expansion of QMH, and whether the Administration had mapped out the timeframe for phase 2 redevelopment of QMH. USFH responded that the new hospital block to be constructed under the Project would accommodate a number of existing clinical departments. The use of the space so vacated would be considered closer to the time of the relocation after taking into account the prevailing healthcare service needs.

Conclusion

22. In closing, the Chairman concluded that the Panel was supportive of the proposed preparatory works for the phase 1 redevelopment project of QMH.

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IV. General Outpatient Clinic Public-Private Partnership Programme in Kwun Tong, Wong Tai Sin and Tuen Mun Districts and progress of other public-private partnership initiatives on chronic disease management
[LC Paper Nos. CB(2)849/13-14(05) and (06)]

23. USFH and D(CS), HA briefed members on details of the General Outpatient Clinic Public-Private Partnership Programme ("the GOPC Partnership Programme") to be launched by HA in Kwun Tong, Wong Tai Sin and Tuen Mun districts, and the progress of existing public-private partnership ("PPP") initiatives on chronic disease, details of which were set out in the Administration's paper (LC Paper No. CB(2)849/13-14(05)).

24. Members noted the background brief entitled "Public-private partnership projects to strengthen chronic diseases management in the primary care setting" (LC Paper No. CB(2)849/13-14(06)) prepared by the LegCo Secretariat.

Effectiveness of PPP programmes on chronic disease

25. Holding the view that the PPP initiatives on chronic disease rolled out by HA in recent years were implemented in a piecemeal manner, Dr Fernando CHEUNG expressed concern about the lack of direction in the development of PPP in healthcare. It was unclear whether these initiatives were temporary measures to supplement public healthcare services due to the current healthcare manpower constraint, or pilot measures for examining the desirability of converting the relevant initiatives into recurrent programmes. In this regard, he remarked that the Labour Party was opposed to any form of privatization of public healthcare services. Mr Albert CHAN said that he was opposed to the promotion of PPP in healthcare, which in his view, would likely result in transfer of benefits to private healthcare sector. Dr Fernando CHEUNG doubted whether the involvement of both HA and private doctors in taking care of a particular chronic disease of the participating patients was conducive to the provision of holistic care to these patients, in particular those suffering from more than one type of chronic diseases.

26. USFH stressed that the Government's commitment to public healthcare remained strong and unchanged. HA was however facing considerable difficulties in service expansion to cater for the ever-growing outpatient service demand from an ageing population due to the current healthcare manpower constraint and physical space limitations. The PPP programmes could provide some relief to the public general outpatient services on the one hand, and on the other hand help foster long-term patient-doctor relationship

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under the family doctor concept and in the longer term, share out the pressure on the public healthcare system by tapping resources in the private sector.

27. Dr Fernando CHEUNG casted doubt on the cost-effectiveness of the PPP programmes in enhancing the provision of healthcare services. As pointed out by the Director of Audit in his Report No. 58, it was estimated that as at December 2010, administrative cost (i.e. $5,736) would account for about 75% of the annual cost per patient (i.e. $7,736) under the Public-Private Chronic Disease Management Shared Care Programme ("SCP"). He sought information about the administrative cost to be incurred under the GOPC Partnership Programme. Mr POON Siu-ping raised a similar question. D(CS), HA explained that the high administrative cost of SCP was due to the lack of economies of scale given the small number of participating patients. Given that it was planned that about 6 000 patients from the three piloting districts would enrol in the GOPC Partnership Programme, it was expected that the administrative cost to be incurred should be lower than that of SCP.

28. Dr Fernando CHEUNG asked whether private healthcare providers participated in the PPP programmes had to include HA as a co-insured party in their professional indemnity insurance policies for the programmes. D(CS), HA advised that HA would not require private healthcare providers participated in the PPP programmes to take out separate professional indemnity insurance for the programmes. The private healthcare providers concerned were however required to have their own professional indemnity insurance. They would be held liable for any damages arising from the treatment they provided to patients participated in the programmes, whereas the responsibilities of HA laid in areas or components delivered by HA for example, the provision of laboratory and x-ray services to these patients as the case might be. A master policy was in place to cover indemnities arising from medical practice of the healthcare professionals working in HA.

Participation rates of the GOPC Partnership Programme

29. Holding the view that the response to the Tin Shui Wai Primary Care Partnership Project ("the TSW Project") was not so encouraging, Prof Joseph LEE doubted how the Administration could attract 6 000 patients to enrol in the GOPC Partnership Programme. Miss Alice MAK asked whether the TSW Project had achieved its targeted numbers of participating patients and private doctors.

30. D(CS), HA advised that when the TSW Project was launched in 2008, it was expected that 1 500 patients and 10 to 15 private doctors practising in Tin Shui Wai would join the Project. The TSW Project was considered to be more successful than SCP. As at December 2013, 1 618 patients and 11 out

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of 32 private doctors practising in Tin Shui Wai (i.e. over 30%) had participated in the TSW Project, whereas only 346 patients and 65 out of 708 private doctors practising in Sha Tin, Tai Po, Wan Chai and Eastern District (i.e. below 10%) had participated in SCP. The much higher participation rate of the TSW Project was possibly due to the fact that participating patients only needed to pay $45 per consultation, which was at the same level of the service fee of the public general outpatient clinic ("GOPC"). Under SCP, participating patients had to co-pay, according to the fees set upfront by individual participating private doctors, ranging from $150 to $1,200 per consultation. Having regard to the operational experience of these two initiatives, patients participated in the GOPC Partnership Programme would only be required to pay the GOPC service fee of $45 for each consultation.

31. Noting that HA would issue invitation letters to about 350 private doctors practising in the three piloting districts in the first quarter of 2014, Mr POON Siu-ping asked whether there was any ceiling on the number of private doctors and patients participated in the GOPC Partnership Programme. Mr WU Chi-wai enquired about the expected participation rate of private doctors.

32. D(CS), HA advised that no limit would be set on the number of patients and private doctors participated in the GOPC Partnership Programme. Making reference to the more than 30% take-up rate of the TSW Project, a more conservative estimation was that 6 000 out of the some 60 000 eligible GOPC patients in the three districts (i.e. 10%) would enrol in the Programme. It was hoped that at least 60 private doctors practising in the districts would participate in the GOPC Partnership Programme. In the longer term, it was expected that each participating private doctor could take care of dozens to 150 participating patients to make the GOPC Partnership Programme more attractive to private doctors. That said, it was difficult to estimate the participation rate of private doctors at this stage, as there were views that the service fees of $320 for each chronic consultation and $238 for each episodic consultation was not attractive. In response to Mr WU Chi-wai's enquiry as to how HA could ensure that the 6 000 places for patients would be fully utilized, D(CS), HA advised that eligible patients in the three districts would be invited to participate in the GOPC Partnership Programme on a voluntary basis by batches.

33. Mr Albert CHAN considered that the participation rate of patients in the PPP programmes for chronic diseases depended on whether the patients could afford to pay the specified consultation fee and whether renowned specialists practising in the districts concerned would enrol in the programmes. He urged HA to put more efforts to encourage renowned specialists to join the

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GOPC Partnership Programme. D(CS), HA assured members that HA would actively encourage more private doctors to participate in the GOPC Partnership Programme so as to provide more choices for participating patients.

Drugs to be prescribed under the GOPC Partnership Programme

34. While supporting the provision of an additional healthcare option for patients, Dr KWOK Ka-ki noted with concern that participating private doctors were required to bear the drug costs by purchasing the drugs listed for the GOPC Partnership Programme ("the Programme Drugs") from HA's drug suppliers at specified prices or using their own drugs. Holding the view that drugs dispensed by public GOPCs were of lower cost and had more side effects than those dispensed by public specialist outpatient clinics and the drug costs in the market were high, he considered that the arrangement was not to the best interests of patients. He urged HA to allow patients to collect the medications recommended by the participating doctors, regardless of whether the drugs were on the list of Programme Drugs, from HA's pharmacy. Dr Fernando CHEUNG echoed Dr KWOK Ka-ki's view. While expressing support for the GOPC Partnership Programme, Mr CHAN Han-pan was concerned that the level of subsidy, instead of the interests of patients, might become the prime consideration of some participating private doctors in prescribing drugs for the participating patients. Mr WU Chi-wai expressed a similar concern. The Chairman sought information about the price level for the Programme Drugs.

35. D(CS), HA responded that drugs dispensed by both public GOPCs and specialist outpatient clinics were of well-established efficacy. Given that the initial target group of the GOPC Partnership Programme was existing GOPC patients having hypertension with or without hyperlipidemia, the arrangement to allow participating doctors to decide whether to use the Programme Drugs, which covered the existing drugs used by these patients, or their own drugs for treating the patients would facilitate continuity of treatment and medication whilst providing flexibility for private doctors to adopt personalized care and treatment for individual patients. D(CS), HA stressed that there was no cause for concern that the quality of treatment and medications provided by the participating doctors would be compromised due to the drive for controlling drug cost, as it was incumbent on all medical practitioners to act in the best interest of their patients. It should also be noted that the prices to be set by HA's drug suppliers for the Programme Drugs would be at the same level as they charged HA.

36. Mr CHAN Han-pan was of the view that measures should be put in place to monitor the treatment and medications provided by the participating

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doctors. Dr KWOK Ka-ki maintained the view that the choice of medications for participating patients under the care of those participating private doctors, in particular those who were in group practices, would likely be compromised because of the drive for cost control. D(CS), HA responded that invitation to enrol in the GOPC Partnership Programme would be issued to private doctors practising in the three piloting districts, regardless of whether they were in solo or group practices.

37. Mr CHAN Han-pan asked whether the participating private doctors could prescribe drugs outside the drug list of the GOPC Partnership Programme to the participating patients enrolled to them. D(CS), HA replied in the affirmative, adding that where appropriate, the participating doctors could discuss with the patients concerned to purchase the drugs at their own cost. The participating doctors could also provide their views on the coverage of the drug list to HA for consideration.

38. In response to the Chairman's enquiry as to whether the participating private doctors could purchase the Programme Drugs for patients outside the GOPC Partnership Programme, D(CS), HA advised that an upper limit would be set on the amount of Programme Drugs each participating doctor could purchase from the drug suppliers of HA based on the number of participating patients under the care of that private doctor. That said, the participating doctors could determine at their sole discretion how to use the drugs so purchased.

Patient and doctors fees of the GOPC Partnership Programme

39. Prof Joseph LEE doubted the need to provide a one-off preparation fee of $185 for the participating doctors with each participating patient enrolled to them under the GOPC Partnership Programme. The Chairman noted that each participating patient would receive up to ten subsidized consultations in a year, covering four follow-up consultations for chronic disease and another six consultations for episodic illness treatment. HA proposed a service fee of $320 for each chronic consultation and a service fee of $238 for each episodic consultation, including the HA GOPC service fee of $45 which would be paid by the patients to the doctors direct after each consultation. He sought information about HA's average cost for providing a GOPC consultation.

40. D(CS), HA advised that the estimated average cost per HA's GOPC attendance was around $380 in 2013-2014. The Chairman queried the reason why the service fee per consultation to be provided by HA to private doctors participated in the GOPC Partnership Programme was lower than its average cost per GOPC attendance. D(CS)HA responded that it was not appropriate to directly compare the two, as the provision of general outpatient services by

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HA involved different healthcare professionals worked in a multi-disciplinary manner. In addition, the target patients of the GOPC Partnership Programme were HA's existing GOPC patients having hypertension with or without hyperlipidemia who were with stable medical conditions, whereas patients of public GOPCs were with various chronic diseases and acute medical conditions. It should also be noted that participating patients could continue to receive relevant laboratory and x-ray services to be provided by HA upon referral by the participating private doctors. Dr KWOK Ka-ki asked whether there was a limit on the maximum number of laboratory and x-ray services that a participating patient could receive. D(CS), HA replied in the negative. In response to Dr KWOK's further enquiry as to whether participating private doctors could refer the participating patients to undergo echocardiogram and exercise electrocardiogram tests, D(CS), HA advised that the referees would be required to be assessed by HA's family medicine specialists on the need to perform these tests.

41. The Chairman did not subscribe to the Administration's views. He remarked that the cost incurred by HA for the provision of laboratory and x-ray services per GOPC attendance was in the range of $600 to $700, and staff cost accounted for 70% to 80% of the average cost per HA's GOPC attendance. Hence, providing the participating private doctors a maximum total payment of $2,708 covering a maximum of 10 consultations with each participating patient enrolled to them would help HA save costs. He asked whether a mechanism would be put in place to review and, where appropriate, adjust the level of service fee to participating doctors. D(CS)HA advised that the level of service fee could be adjusted in future on the basis of the medical inflation index, and an overall review would be conducted after two years of Programme implementation.

42. Miss Alice MAK considered that the Administration should provide justifications that it would be more cost effective to use the public money to support the implementation of the GOPC Partnership Programme, instead of using the resources to enhance the service capacity of public GOPCs. Given that the design of the GOPC Partnership Programme had made reference to the operational experience of the TSW Project, she requested HA to provide the total expenditure (including the service fees to participating private doctors, and the costs for drugs and relevant laboratory and x-ray services provided by HA) incurred under the TSW Project and the average cost per consultation for each participating patient. D(CS), HA agreed to provide the information after the meeting. At the request of the Chairman, D(CS), HA agreed to provide after the meeting information explaining the amount of service fee to be provided by HA to a doctor for a consultation which involved both chronic and acute care, as well as the arrangement to reimburse the participating doctors the service fees borne by HA under the GOPC

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Partnership Programme.

43. The Chairman noted that under mutual agreement, individual patients could receive further services and treatment provided by the participating private doctors at their own expenses. He considered that this arrangement was feasible only if there were clear descriptions of the scope of services and treatment to be received under the GOPC Partnership Programme. D(CS), HA responded that the prescribed service fees for each chronic consultation covered the costs for consultation, Programme Drugs and clinic administration; whereas that for each episodic consultation included three days' episodic illness drugs and antibiotics within the list of Programme Drugs. Other than the above, services and treatment such as vaccine injection and medical check-up provided by the doctors would be outside the GOPC Partnership Programme and patients had to bear the cost out of their own pocket. Those participating patients who were aged 70 or above and had joined the Elderly Health Care Voucher Scheme could meet the additional charges arising from these services and treatment from their Voucher accounts.

Impact of the GOPC Partnership Programme on the public healthcare system

44. Prof Joseph LEE asked to what extent the Programme could help increase the service capacity of public GOPCs. D(CS), HA responded that apart from providing some relief to HA's general outpatient services, it was hoped that as some GOPC patients chose to make use of private healthcare services under the GOPC Partnership Programme, it would better enable the HA to increase the duration of consultation for each GOPC patient.

45. Mr Albert HO pointed out that at present, many patients with non-urgent medical needs would seek public A&E services during the hours when public GOPCs were not in service. Holding the view that these patients could instead be managed by private family doctors participated in the GOPC Partnership Programme, he urged HA to encourage more participating doctors to provide round-the-clock services with a view to relieving the heavy burden for public A&E services. D(CS), HA advised that it was not uncommon that private doctors in Hong Kong would provide late-evening or even late-night services. HA would closely monitor the implementation of the GOPC Programme and keep in view feedback from private doctors and patients in considering how the Programme could be taken forward.

Implementation of the GOPC Partnership Programme

46. In response to Mr WU Chi-wai's enquiry about the implementation timetable for the GOPC Partnership Programme, D(CS), HA advised that HA

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would issue invitation letters to private doctors in the three piloting districts at the end of March 2014. After compiling the district lists of participating private doctors, identified eligible GOPC patients in each of these three districts would be invited to enrol, on a voluntary basis, in June 2014, and select a private doctor from the list as their family doctors. It was planned that participating patients could seek consultation from their selected doctors after July 2014.

47. Mr CHAN Han-pan asked whether participating patients were allowed to return to HA's GOPCs for treatment. D(CS), HA advised that patients could withdraw from the Programme and revert to HA's outpatient clinics for chronic disease follow-up if they so wished. Patients who were dissatisfied with the services provided by their selected private doctors could also choose another private doctor on the list.

48. Dr Fernando CHEUNG sought information about the exit arrangements in case the GOPC Partnership Programme was later terminated for various reasons. D(CS), HA advised that the participating patients would be invited to revert to HA's GOPCs for treatment. In response to Dr Fernando CHEUNG's further enquiry as to whether the return of some 6 000 patients would pose a heavy burden to HA, D(CS), HA advised that there was no cause for such concern. It should also be noted that there would be an increase in the number of local medical graduates starting from 2015-2016.

Evaluation of the GOPC Partnership Programme

49. Dr Fernando CHEUNG noted that an interim review would be conducted in six to 12 months after the launching of the GOPC Partnership Programme and a full review was planned after two years of Programme implementation. He opined that apart form collecting feedback from the participants on whether they were satisfied with the Programme, the Administration and HA should also examine the impact of the Programme on the healthcare seeking behaviour and health conditions of the participating patients, and compare the cost-effectiveness of providing the relevant treatment at public GOPCs against partnering with the private healthcare providers.

50. In response to the Chairman's enquiry on when the Administration and HA would revert to the Panel on the progress of the GOPC Partnership Programme, D(CS), HA undertook to revert to the Panel on the progress one year after the implementation of the Programme.

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V. Any other business

Visit on the operation of the Electronic Health Record Sharing System

51. The Chairman reminded members that a visit on the operation of the proposed Electronic Health Record Sharing System had been scheduled for 28 February 2014. Members who wished to join the visit were requested to inform the LegCo Secretariat by 21 February 2014.

52. There being no other business, the meeting ended at 6:31 pm.

Council Business Division 2
Legislative Council Secretariat
23 May 2014