立法會
Legislative Council

LC Paper No. CB(2)46/14-15
(These minutes have been seen by the Administration)

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Panel on Health Services

Minutes of meeting
held on Monday, 28 April 2014, at 4:30 pm
in Conference Room 1 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 Vincent FANG Kang, SBS, JP Hon WONG Ting-kwong, SBS, JP Hon CHAN Kin-por, BBS, JP Hon CHEUNG Kwok-che 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	:	Dr Hon Priscilla LEUNG Mei-fun, SBS, JP Hon Mrs Regina IP LAU Suk-yee, GBS, 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

Mr Chris SUN Yuk-han, JP
Head, Healthcare Planning and Development Office
Food and Health Bureau

Dr K L CHUNG
Chief Manager, Integrated Care Programs
Hospital Authority

Item IV

Miss Wendy AU
Principal Assistant Secretary for Food & Health (Health) Special Duties 1

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

Dr Alexander CHIU
Chief Manager (Quality & Standards)
Hospital Authority

Dr N M LAM
Consultant Ophthalmologist
Hong Kong Eye Hospital
Hospital Authority

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

Staff in attendance : Ms Janet SHUM
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 Nos. CB(2)1254/13-14(01) and CB(2)1375/13-14(01)]

Members noted the following papers issued since the last meeting -

(a) Referral from the Public Complaints Office of the Legislative Council ("LegCo") Secretariat on issues relating to protection for the working elderly; and

(b) Letter dated 24 April 2014 from Dr Helena WONG requesting the Research Office of the LegCo Secretariat to conduct a research on the regulation of beauty industry in overseas places.

2. The Chairman sought members' views on Dr Helena WONG's proposal as detailed under item (b) above. He remarked that the then Research Division of the LegCo Secretariat had prepared an information note on the regulation of aesthetic practices in Singapore for members' reference when the subject "Review on the regulation of medical beauty treatments/procedures" was discussed at the special meeting of the Panel on 26 October 2012. At the request of members, the Administration had provided supplementary information on regulation of medical beauty treatments/procedures in the United Kingdom ("UK"), Canada, Maryland of the United States, Singapore and the Mainland after the meeting.

3. Dr Helena WONG said that in view of the Administration's recent review on the types of cosmetic procedures recommended to be performed only by registered medical practitioners or registered dentists, and its on-going review on the regulatory framework for medical devices which covered, among others, cosmetic-related medical devices, there was a need for members to be more well-informed of the regulatory approaches adopted by overseas places, such as the European Union, UK, and the Republic of Korea, to regulate aesthetic practices to facilitate future discussion. Members raised no objection. The Chairman said that the Clerk would follow up with the Research Office accordingly.

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II. Items for discussion at the next meeting

[LC Paper Nos. CB(2)1340/13-14(01) and (02), CB(2)1251/13-14(01), CB(2)1328/13-14(01), CB(2)1382/13-14(01) and CB(2)1364/13-14(01)]

Items for discussion at the next regular meeting

4. Members agreed to the Administration's proposals to discuss the "Refurbishment of Hong Kong Buddhist Hospital" and to receive views from deputations on the "Development of Chinese medicine hospital and integrated Chinese-Western medicine" at the next regular meeting scheduled for 19 May 2014 at 4:30 pm.

Other issues of concern

5. The Chairman referred members to the emails from a member of the public proposing the Panel to discuss matters relating to the complaint handling mechanism of the Medical Council of Hong Kong (LC Paper Nos. CB(2)1251/13-14(01) and CB(2)1382/13-14(01)) and the Administration's response on the matter (LC Paper No. CB(2)1364/13-14(01)). At the suggestion of the Chairman, members agreed that the issue be included in the Panel's list of outstanding items for discussion.

6. Members noted the joint letter dated 9 April 2014 from 天水圍婦女健康關注小組 and Tin Shui Wai Community Development Alliance requesting the Panel to discuss issues relating to the provision of public healthcare services for women (LC Paper No. CB(2)1328/13-14(01)). The Chairman advised that the Duty Roster Members of the Public Complaints Office of the LegCo Secretariat would meet with the deputations to receive their views on the subject shortly. Members could consider following up the matter should the Duty Roster Members make referral to the Panel after meeting with the deputations. Members raised no objection.

7. Referring to the recent media report on the private patient service provided by a teaching staff of the Faculty of Medicine of The University of Hong Kong, Dr KWOK Ka-ki suggested that issues relating to the provision of private patient services by the teaching staff of the two local universities with medical faculties at the two teaching hospitals be discussed at a future meeting of the Panel. Members agreed.

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III. Mental health services for adults

[LC Paper Nos. CB(2)1340/13-14(03) and (04)]

8. Under Secretary for Food and Health ("USFH") briefed members on the progress of the mental health review being conducted by the Food and Health Bureau ("FHB") and proposals for strengthening mental health services provided by the Hospital Authority ("HA") for adults, details of which were set out in the Administration's paper (LC Paper No. CB(2)1340/13-14(03)).

9. Members noted the background brief entitled "Mental health services for adults" (LC Paper No. CB(2)1340/13-14(04)) prepared by the LegCo Secretariat.

Timetable and scope of the review

10. Dr KWOK Ka-ki expressed disappointment that the paper provided by the Administration had not responded to the changing needs of the community in which depression and anxiety disorder had become an imminent issue leading to an increasing number of suicidal cases. He urged the Administration to come up with a concrete action plan with a timetable for improving mental health services. Dr Fernando CHEUNG asked whether there was a timeframe for the Review Committee on Mental Health ("the Review Committee") to complete its study and formulate a blueprint mapping out a comprehensive mental health policy.

11. Dr Elizabeth QUAT enquired whether the Administration had studied the demand from elders for psychogeriatric services in the next decade in view of the ageing population, and if so, when the results would be available. Pointing out that dementia was a common disease that struck in the old age, Dr Fernando CHEUNG expressed concern that while HA would arrange social service referrals as appropriate for patients with dementia living in the community, HA could hardly ensure that the care services so provided under the ambit of Social Welfare Department ("SWD") could meet the needs of the patients. Mr CHEUNG Kwok-che remarked that SWD's Integrated Community Centres for Mental Wellness ("ICCMWs") might not be the most appropriate platform to follow up the demented cases, albeit that many such cases were referred to ICCMWs for follow-up.

12. USFH explained that the paper aimed to brief members on some possible directions for enhancing the mental health services observed by the Review Committee which, with its two expert groups on dementia care and mental health services for children and adolescents, was continuing the review on the various fronts. It was expected that the Review Committee would

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complete its review in a year's time. The Administration would publish the recommendations of the Review Committee upon completion of the review. Dr Helena WONG was concerned that the Review Committee was working behind closed door. USFH advised that there was no cause for such concern, as the Review Committee comprised members with wide representation, including academics, healthcare professionals, service providers, service user and caregiver, as well as representatives from the Equal Opportunities Commission and the Hong Kong Council of Social Service.

Healthcare manpower for mental health services provided by HA

13. Dr KWOK Ka-ki enquired how far HA had enhanced its psychiatric manpower resources in 2013-2014 to expedite the handling of cases. Chief Manager, Integrated Care Programs, HA ("CM(ICP), HA") advised that the number of psychiatric doctors and psychiatric nurses had respectively increased from 332 in 2012-2013 to 337 in 2013-2014, and from 2 296 in 2012-2013 to 2 368 in 2013-2014. As regards clinical psychologists and occupational therapists working in psychiatric stream in HA, their number had respectively increased from 65 in 2012-2013 to 67 in 2013-2014, and from 218 in 2012-2013 to 230 in 2013-2014.

14. In response to Mr POON Siu-ping's enquiry as to whether HA would recruit additional medical manpower in 2014-2015 to further increase its service capacity in handling cases with mental illness, Director (Cluster Services), HA ("D(CS), HA") advised that there was a shortfall of 301 doctors in HA in 2013-2014, of which 23 vacancies were in psychiatric stream. It was expected that the psychiatric stream, which remained a pressure area, would be accorded priority in the allocation of the Resident Trainee positions in July 2014 for maintaining its existing services and implementing the service enhancement measures.

Psychiatric outpatient services of HA

15. Dr KWOK Ka-ki noted that new cases received at HA's psychiatric specialist outpatient clinics ("SOPCs") would be triaged into priority one (urgent), priority two (semi-urgent) and routine cases according to their severity and urgency. He enquired about the longest waiting time for the first appointment of the routine cases. D(CS), HA advised that HA sought to keep the median waiting time for first appointment at SOPCs for priority one and priority two cases under two weeks and eight weeks respectively. For routine cases, the longest waiting time for first appointment was up to one and a half years, and these were cases of children with less urgent conditions like most cases of Attention Deficit Hyperactivity Disorder.

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16. Miss Alice MAK pointed out that the benefit coverage of existing private health insurance products in the market did not include mental illness. Hence, patients who were unable to afford private healthcare services had to rely on the public healthcare system. In her view, it was unacceptable to require these patients, if being classified as routine cases under the triage system, to wait for a year or so for their first appointment in SOPCs. D(CS), HA admitted that it would be unsustainable to rely solely on the public healthcare sector to take care of persons with mental illness. As part of the efforts to ease the existing bottleneck in psychiatric services and shorten the waiting time at SOPCs, the role of primary care in treating patients with common mental disorders ("CMD") would be further explored. HA would also enhance the multi-disciplinary element in its service delivery model by engaging more psychiatric nurses, clinical psychologists and allied health professionals to provide active intervention for CMD patients, so that doctors could devote more time to managing new cases.

17. Citing an incident whereby a patient committed suicide the next day after undergoing assessment under the triage system at SOPCs, Dr KWOK Ka-ki opined that the two-week median waiting time for first appointment at SOPCs for priority one cases might still be too long. He also expressed concern about the possibility of urgent cases being wrongly classified as semi-urgent or routine cases.

18. D(CS), HA advised that the purpose of putting in place a triage system for news cases received at SOPCs was to ensure that more urgent and severe cases were followed up promptly. All new patients that had been classified as routine cases would be reviewed by a senior doctor of the relevant specialty within seven working days of the initial triage. In any case, if a patient's condition deteriorated before the appointment, the patient might contact the SOPC concerned and request for an earlier appointment. If the condition was acute, the patient could also seek immediate treatment at the Accident and Emergency departments of HA. Where necessary, the patients concerned would be referred to psychiatric hospitals for receiving treatment.

19. Dr Elizabeth QUAT asked whether HA would consider providing evening services at public psychiatric SOPCs so that mental patients who had to work during daytime could schedule their follow-up consultations in the evening. The provision of such services would also facilitate members of the public to seek help for cases of suspected mental health problems in the community which required urgent attention. CM(ICP), HA responded that while HA was aware of the demand for psychiatric specialist evening outpatient service, it had no immediate plan to provide such services given the current medical manpower constraint. To provide support for patients with daytime employment, HA has recently established, designated depot

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clinics in all seven hospital clusters which provide injection services for patients during non-office hours. Dr Elizabeth QUAT did not subscribe to HA's explanation, pointing out that medical manpower shortage should not hamper HA's provision of services to facilitate mental patients' recovery in the community.

Support services for patients with CMD

20. Mr POON Siu-ping sought clarification as to whether mood disorders was same as affective disorders and fell within the category of CMD. Replying in the affirmative, D(CS), HA explained that symptoms of affective disorders included mania and depression. Affective disorder was different from schizophrenia, which was the predominant severe mental illness, that often caused functional disabilities.

21. Dr Helena WONG was concerned about the increasing number of women suffering from mood disorders and stress-related disorders, which was more than one fold of the number of men suffering from the same illnesses. Given that patients with CMD were often reluctant to seek consultation at psychiatric SOPCs and take medication to avoid being labeled as persons with mental health problems, she enquired whether there were any support services in place for these patients. D(CS), HA advised that patients with mild mental illness were currently provided with diagnosis, treatment and other support services, including individual or group counselling and psychological treatment, by multi-disciplinary teams in primary care settings at cluster-based designated general outpatient clinics.

Detection of persons with suspected mental health problems

22. Sharing her experience in handling cases involving persons with suspected mental health problems causing nuisances in the neighbourhood but refused to receive treatment for their mental conditions, Dr CHIANG Lai-wan enquired about the measures in place for early identification of and timely intervention for persons suspected to have mental problems living in the community. Miss Alice MAK raised a similar question.

23. USFH advised that the Review Committee would examine the need and feasibility of introducing community treatment order having regard to overseas experiences and factors such as a patient's right to decide the form of healthcare he/she would like to have and human rights. D(CS), HA supplemented that according to the Mental Health Ordinance (Cap. 136), an application might be made by HA to a District Judge or magistrate for detention of a patient who was suffering from mental disorder of a nature or

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degree which warranted his/her detention in a mental hospital for at least a limited period for observation, in the interests of the patient's own health or safety or with a view to the protection of other persons.

24. Mr CHAN Kin-por said that studies had revealed that hidden adults and adolescents were more prone to be persons with mental health problems. He asked whether the Administration had estimated the population of such persons and whether there were any mechanisms in place for HA or SWD to identify and provide timely intervention for these persons. D(CS), HA advised that HA would accept referrals from social workers or schools if they discovered any person with suspected mental health problems in the community. Training had been provided by HA for social workers of SWD and schools on how to identify persons with suspected mental health problems. It should also be noted that family doctors in the private sector played an important role in identifying cases of mental illness in the primary care setting.

Cross-sectoral collaboration

25. Dr Helena WONG relayed the views of frontline workers that the existing manpower and financial resources for the provision of community support services for patients with mental illness living in the community were far from adequate to meet the needs of patients. She was concerned about the measures to be put in place to ensure effective collaboration among stakeholders from the medical and social care sectors in providing community mental health services for these patients. Holding the view that family support was important to patients with mental illness residing in the community, Mr CHEUNG Kwok-che asked how HA would work with ICCMWs to enhance the willingness and ability of family members or carers of patients with mental illness to take care of these patients in the community setting. In addition, home visits paid by social workers of ICCMWs to these families should be counted as Funding and Service Agreement activities.

26. Citing the practices that two case managers were responsible for providing support for the same patient with severe mental illness residing in the community under HA's Case Management Programme and SWD's ICCMW respectively, and children with mental health problems were not considered by the Education Bureau as students with special education needs as examples, Dr Fernando CHEUNG was of grave concern over the lack of effective collaboration among different policy bureaux and government departments in supporting patients with mental illness. Sharing Dr Fernando CHEUNG's concern, Miss Alice MAK considered that the first and foremost task of the Review Committee was to formulate a mechanism

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to ensure seamless collaboration among different sectors involved in the provision of mental health services. Dr Fernando CHEUNG was of a strong view that the problem could only be tackled effectively through the establishment of a dedicated mental health council.

27. USFH advised that medical-social collaboration was one of the issues under the study of the Review Committee which comprised representatives from the Labour and Welfare Bureau and SWD. She would relay members' views to the Review Committee for consideration. It should be noted that HA and SWD had instituted a three-tier collaboration platform in 2010 to facilitate cross-sectoral communication at the central, district and service delivery levels. HA and SWD had set up a task group to revisit the existing service model with a view to developing a service framework for enhancing collaboration and communication between the medical and social care sector. It was hoped that a draft service framework would be ready for consultation with stakeholders, including patient groups, by end of 2014. D(CS), HA supplemented that for patients with severe mental illness residing in the community, HA would review the case manager to patient ratio of the Case Management Programme, with a view to strengthening the personalized and intensive support provided by case managers to these patients. He agreed that family support was important to patients with mental illness residing in the community, and HA and SWD would enhance their collaboration in providing support to family members or carers of these patients.

28. Mr Albert CHAN considered that the Government should be held accountable for the increasing number of persons suffering from mental health problems, as it had failed to formulate policies to meet the aspiration of the community for a healthy living environment. USFH advised that the Government aimed to promote mental health through a service delivery model that covered prevention, early identification, medical treatment and rehabilitation services.

Way forward

29. Dr KWOK Ka-ki suggested that the Panel should invite views from relevant stakeholders and members of the public on the subject of mental health policy and services. Dr Helena WONG concurred with Dr KWOK and remarked that input from healthcare professionals, service providers and service users was conducive to the formulation of a comprehensive mental health policy. Members agreed to the suggestion. The Chairman said that the Clerk would follow up on the meeting arrangements. Members would be informed of the meeting date in due course.

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(*Post-meeting note*: At the suggestion of the Administration, members agreed at the meeting on 19 May 2014 that the Panel would receive views from the relevant stakeholders and members of the public on the subject "Mental health policy and services" at the regular meeting of the Panel on 16 June 2014.)

IV. Provision of cataract surgeries in the Hospital Authority

[LC Paper Nos. CB(2)1340/13-14(05) and (06), CB(2)1374/13-14(01)]

30. USFH, D(CS), HA and Consultant Ophthalmologist, Hong Kong Eye Hospital ("Consultant Ophthalmologist, HKEH") briefed members on the latest position regarding the provision of cataract surgeries in HA and the progress of HA's Cataract Surgeries Programme ("CSP"), details of which were set out in the Administration's paper (LC Paper No. CB(2)1340/13-14(05)).

31. Members noted the updated background brief entitled "Provision of cataract surgeries in the Hospital Authority" (LC Paper No. CB(2)1340/13-14(06)) prepared by the LegCo Secretariat.

32. Members also noted a submission from 爭取老人福利聯會 on the subject (LC Paper No. CB(2)1374/13-14(01)).

Waiting time of cataract surgeries at different hospital clusters

33. Dr KWOK Ka-ki expressed grave concern about the disparity between the notional waiting time of cataract surgeries in the Hong Kong West ("HKW") cluster and that in the New Territories West ("NTW") cluster, which stood at two months and 22 months respectively in 2013-2014 (as at December 2013). Dr Helena WONG was particularly concerned about the long waiting time in the Kowloon West ("KW") and NTW clusters when compared with other hospital clusters.

34. USFH responded that HA had established Cataract Centres at Grantham Hospital of HKW cluster and Tseung Kwan O Hospital of the Kowloon East cluster in 2009 and 2011 respectively with an aim to boost up service capacity, reduce waiting time and improve efficiency through high volume cataract surgery. This partly explained the substantial reduction in the notional waiting time for cataract surgeries in the HKW cluster. A cross-cluster referral mechanism was in place to refer patients in clusters of longer waiting time to clusters of shorter waiting time. HA had also uploaded the waiting time for cataract surgeries on its website since April 2013 to facilitate patients' understanding of the waiting time situation in HA and

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made informed decisions in treatment choice and plans. D(CS), HA supplemented that the establishment of a high volume Cataract Centre at Grantham Hospital, which was the first of its kind in Hong Kong, through optimizing the utilization of its site area was a pilot measure to shorten the notional waiting time for cataract surgeries for the cluster.

35. In response to Dr Helena WONG's enquiry about the timetable of HA to narrow the disparity of the waiting time of cataract surgeries among different hospital clusters, D(CS), HA advised that at present, HA sought to carry out elective cataract surgery within two months for priority one patients (i.e. urgent cases such as mature cataract, eye with poor vision), and within 12 months for priority 2 patients (i.e. early cases such as for occupational needs). HA would endeavour to maintain the waiting time of 12 to 24 months for patients on the clusters' routine cataract surgery waiting list. The Chairman remarked that according to the President of the College of Ophthalmologists of Hong Kong, Hong Kong's ratio of throughput of cataract surgeries to the population had started to surpass that of some European countries and the United States. This phenomenon showed that some patients might have been put on the waiting list and receive the surgery earlier than needed.

Cross-cluster referrals

36. Dr KWOK Ka-ki was of the view that the uploading of the waiting time for cataract surgeries on HA's website was of little help for elderly patients who rarely accessed the internet. He urged HA to proactively invite patients on the waiting list to undergo cataract surgeries at clusters of shorter waiting time. Dr Helena WONG held a similar view. Expressing concern that the notional waiting time of four out of the seven hospital clusters was more than 12 months, Dr Fernando CHEUNG considered that HA should put in place a centralized mechanism for cross-cluster referral with a view to aligning the waiting time of all hospital clusters. In his view, HA should enhance patients' awareness of the referral mechanism and strengthen the Easy-Access Transport Service so as to facilitate the elderly patients to travel from their homes to other hospital clusters to receive cataract surgeries. Mr Albert HO enquired whether the elderly patients' reluctance to join the referral programme was due to traffic inconvenience.

37. D(CS), HA advised that under the cross-cluster referral mechanism, efforts had been made by HA to invite patients on the waiting list to give their consent for referral to those clusters with shorter waiting time for cataract surgeries, such as the HKW cluster. There were also point-to-point transfer services between homes and the public hospitals concerned. This notwithstanding, only around 100 patients had given their consent to do so,

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as many elderly patients considered the around 14-month notional waiting time acceptable and preferred to remain on the waiting list of their respective cluster. D(CS), HA added that while patients who had been on HA clusters' routine cataract surgery waiting list might find blurring in their vision, their daily lives would not be much affected. Hence, many of them did not consider that they had an urgent need to undergo the cataract surgeries. That said, efforts would continue be made to encourage patients on the waiting list to receive cataract surgeries at clusters of shorter waiting time.

38. Dr Helena WONG sought clarification as to whether frontline doctors would inform patients on the waiting list about the cross-clusters referral mechanism and seek their consent to referral during consultation. D(CS), HA explained that elderly patients often could not make up their mind to accept referral during consultation and needed to take time to discuss with their family members on the matter. He reiterated that elderly patients were often reluctant to visit other hospital clusters which were unfamiliar to them. A more effective way of shortening the waiting list of cataract surgeries was to increase surgeries throughput by increasing the number of operating theatre sessions. The Chairman suggested that Members' offices could make referral to HA should they come across cases whereby the patient concerned was willing to receive surgery at hospital clusters of shorter waiting time.

39. In response to Dr Fernando CHEUNG and Mr Albert HO's enquiries about the consultation arrangement before and after the cataract surgery under the cross-cluster referral mechanism, D(CS), HA advised that the patient concerned would need to visit the referral hospital a few times prior to undergoing the surgery. The daytime surgery would be performed on one eye at a time. The original hospital cluster the patient belonged to would provide follow-up consultations after the surgery.

Setting up of Cataract Centres

40. Miss Alice MAK noted with concern from Annex B of the Administration's paper that while the notional waiting time of cataract surgeries in most hospital clusters had been shortened since 2009-2010, the notional waiting time of KW and NTW clusters had become lengthened. She asked whether high volume Cataract Centres could be established in these two clusters. Dr Helena WONG raised a similar question.

41. D(CS), HA explained that apart from cataract surgeries, there was a longer waiting time for operations of major specialties in HA, such as oncology surgeries. The severe manpower shortage experienced by the public healthcare sector in recent years and the lack of operation theatre

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facilities for operations were some of the reasons leading to an overall increase in waiting time for surgeries. In the next three years, HA would increase the number of operating theatre sessions to improve access to surgeries. While the urgent surgical need of cancer patients would be accorded priority, HA would also address the demand for elective surgeries of non-urgent nature, such as elective cataract surgery, as far as possible. In response to Miss Alice MAK's enquiry as to whether additional operating theatre sessions would be opened in the Tuen Mun Hospital, D(CS), HA advised that HA was working on the details.

CSP

42. Dr KWOK Ka-ki asked whether assistance would be provided for those patients who were not on CSSA but could not afford paying the co-payment of no more than $8,000 to undertake cataract surgeries in the private sector under CSP. The Chairman, Dr CHIANG Lai-wan, Miss Alice MAK and Dr Fernando CHEUNG expressed similar views. Dr CHIANG Lai-wan noted from paragraph 9 of the Administration's paper that HA had invited a total of 72 764 eligible patients on the waiting list for cataract surgeries to join CSP, of whom only 19 343 patients had joined the Programme. She asked whether consideration could be given to relaxing the eligibility criteria and allowing those patients on the waiting list who could afford the co-payment but not being invited to join CSP.

43. USFH responded that for patients with limited economic means such as the CSSA recipients and those granted medical fee waiver, they could choose to receive surgeries without co-payment in public hospitals through additional operating services. The Administration and HA had no plan to increase the subsidy amount and change the eligibility criteria of CSP at this stage. D(CS), HA advised that any public-private partnership programmes should be carefully designed to avoid attracting patients who could have afforded private healthcare services to resort to the public healthcare system and hence, affecting the service provision of the public sector as a whole. In the case of CSP, an around 24-month waiting time for cataract surgeries in HA was considered reasonable by private ophthalmologists.

44. The Chairman said that to his understanding, the average cost per cataract surgery in HA was about $14,000. Given that the Government only subsidized $5,000 for each patient joining CSP, it would be highly cost effective for HA to increase the number of participants of CSP through allowing patients who had been on the waiting list for one year or more (instead of two years or more as required) to join CSP. The Chairman remarked that the concern of the private sector over CSP was in fact more about HA's capping of their charges for each cataract surgery at $13,000 (i.e.

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a fixed Government subsidy of $5,000 subject to a co-payment of not more than $8,000 by the patient). He did not foresee that relaxing the eligibility criteria for patients to participate in CSP or increasing the amount of Government subsidy for each cataract surgery would have an adverse impact on the private sector. To help clearing the backlog of HA's waiting list of cataract surgeries under the constraint of limited service capacity, the Chairman suggested that HA could consider outsourcing the service to the private sector to provide fully subsidized cataract surgeries to the patients. The outsourced service would only need to last as long as the backlog of the waiting list in the hospital clusters was cleared. D(CS), HA said that while HA kept an open mind on the Chairman's suggestion, it would need to continue to discuss the way forward with the private sector as CSP was a public-private partnership programme.

45. There being no other business, the meeting ended at 6:27pm.

Council Business Division 2
Legislative Council Secretariat
10 October 2014