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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 2013-2014 Legislative Council ("LegCo") session. It will be tabled at the Council meeting of 9 July 2014 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 Prof Hon Joseph LEE Kok-long elected as Chairman and Deputy Chairman respectively. The membership list of the Panel is in **Appendix II**.

Major work

Development of Chinese medicine hospital

4. The Panel continued to follow up closely the development of Chinese medicine in Hong Kong. Following the Chief Executive's announcement in the 2014 Policy Address to accept the recommendation of the Chinese Medicine Development Committee ("CMDC") on reserving a site in Tseung Kwan O for setting up a Chinese medicine hospital with 400 beds, members were briefed by the Administration in March 2014 on,

among others, its proposals of developing the hospital and integrated Chinese-Western medicine ("ICWM"). The Panel received views from interested parties on the subject at another meeting in May 2014.

5. Given that the direction and focus of development for Chinese medicine services in the past had been on outpatient services, the Panel had long been calling for the establishment of a Chinese medicine hospital to provide inpatient services for members of the public and training grounds for local Chinese medicine graduates. Members therefore welcomed the proposed setting up of a Chinese medicine hospital. They were however disappointed at the lack of a commissioning timetable for the hospital.

6. Of equal concern to members was the preliminary view of CMDC that it would be more feasible for an operating body to run the hospital on a self-financing basis with ICWM, rather than pure Chinese medicine, as the mode of operation. Some members urged the Administration to provide recurrent subvention to the hospital to ensure that its services would be affordable to most of the public. Some members went further to suggest that the hospital should be a public hospital operated within the Hospital Authority ("HA") system. There was a concern that the support to be provided by the hospital in areas of teaching, clinical internships and scientific research would be limited if the three local universities offering University Grants Committee-funded full-time degree programmes in Chinese medicine would have no involvement in its operation. There was a strong call from members and many deputations that the development directions for, and the running of, the hospital should be based on the perspective of Chinese medicine, rather than a Western medicine perspective.

7. The Administration explained that it would not be feasible to set up a Chinese medicine hospital providing only Chinese medicine services as the local healthcare system was based on Western medicine. It, however, assured members that Chinese medicine practitioners would assume a leading role in the provision of clinical service in the hospital. The Administration would continue to work with CMDC, which was comprised of, among others, representatives from the Chinese medicine practice, Chinese medicines trade and academia, on the setting up of the hospital and regulation of ICWM and Chinese medicine inpatient services. These apart, HA would carry out an ICWM pilot project for stroke rehabilitation, low back pain and palliative care for cancer in public hospitals in the third quarter of 2014. The experiences gained would serve as the basis for formulating the regulation for the mode of operation of a Chinese medicine hospital.

8. The Panel passed a motion at the May meeting urging the Government to, among others, expeditiously implement the establishment of a Chinese medicine hospital, and incorporate the hospital and the 18 Chinese Medicine Centres for Training and Research (or commonly known as "Chinese medicine clinics") into the public healthcare system. To enable more focused discussion, the Panel agreed at its meeting on 16 June 2014 to appoint a subcommittee to study issues relating to the development of Chinese medicine and make timely recommendations. The subcommittee would commence work when a vacant slot became available to accommodate its activation.

Regulation of cosmetic procedures classified as medical procedures

9. Given the grave public concern about the adverse incident in October 2012 involving a beauty centre inappropriately offering high-risk invasive procedures ("the adverse incident"), a major focus of the Panel during the last legislative session was the differentiation between medical procedures and cosmetic services. When the Administration briefed the Panel nearly a year later on the recommendations put forth by the Working Group on Differentiation between Medical Procedures and Beauty Services ("the Working Group") as endorsed by the Steering Committee on the Regulation of Private Healthcare Facilities that procedures involving injections, mechanical or chemical exfoliation of the skin below the epidermis and hyperbaric oxygen therapy should be performed by registered medical practitioners; and that dental bleaching should be performed by registered dentists, members in general agreed that beauty service providers who were not themselves registered medical practitioners or registered dentists should refrain from performing these procedures in view of their inherent risks. Members, however, raised concern about the impact to be brought about by the recommendations on the trade and consumers undergoing cosmetic procedures. The Panel met with stakeholders including those from the medical and beauty sectors, as well as consumer and patient groups, at a subsequent meeting to listen to their views on the recommendations and related issues.

10. Some members drew to the Administration's attention that the adverse incident was caused by professional misconduct on the part of the medical practitioner concerned, and enforcement actions against persons who practised medicine/surgery or dentistry without registration should be stepped up. They also urged the Administration to ensure that registered medical practitioners and registered dentists, in particular those associating with beauty service companies, would act in the patients' best interests when performing the aforesaid procedures. There were also views that the Administration should proactively inspect those beauty service

companies suspected of involving in the provision of medical procedures, step up publicity on health risks associated with cosmetic procedures and how to select safe beauty services.

11. As undertaken by the Administration, the Department of Health ("DH") would strengthen market surveillance and collaborate with the Consumer Council to identify suspected violation of the Medical Registration Ordinance (Cap. 161) and the Dentists Registration Ordinance (Cap. 156), and raise public awareness on the risks associated with cosmetic procedures via various media channels. Members noted that DH would also issue letters to registered medical practitioners and registered dentists reminding them to strictly observe the Code of Professional Conduct issued by their Councils when they provided cosmetic procedures in their professional practice, and issue an advisory note to beauty service providers to remind them to refrain from these procedures.

12. Members shared the concern of the deputations from the beauty sector that the composition of the Working Group had not been able to ensure a balanced representation of views during the discussion process. They called on the Administration to actively engage the beauty sector in taking forward the Working Group's recommendations. Some members were concerned about the impact of the enhanced regulation of the aforesaid procedures on the livelihood of the frontline beauticians, many of whom had acquired recognition in respect of their expertise for performing certain advanced cosmetic procedures. Most of the deputations from the beauty sector submitting views to the Panel advocated the formulation of a separate regulatory regime for the beauty profession with a view to promoting the sustainable development of the industry. The Panel passed a motion urging the Government to set up a steering committee on regulation of beauty industry and work with the beauty industry in formulating a set of regulatory and training regime for the profession.

13. According to the Administration, it had adopted a risk-based approach focusing on those procedures or treatments that were intrinsically risky and could cause considerable harm to clients if not properly administered by qualified personnel. The remaining practices of the beauty industry were non-intrusive and involved no or very little health risks that called for direct regulatory intervention. It did not have any plan to put in place a regulatory framework for the beauty industry to regulate the industry indiscriminately at this stage. The Panel would continue to follow up the subject matter with the Administration, and had requested the Research Office of the LegCo Secretariat to conduct a research on the regulation of aesthetic practices in selected overseas places including Florida of the United States, Singapore, South Korea and the

United Kingdom to facilitate its future discussion on the matter. The research was expected to complete in September 2014.

Proposed regulatory framework of medical devices

14. The establishment of a long-term statutory system to regulate the import, distribution, sale or use of medical devices had all long been of considerable concern to the Panel. During the session, the Panel was briefed on the latest development of the proposed regulatory framework for medical devices. Members noted that the Administration had made several changes to the original regulatory framework proposed in 2010.

15. Of particular concern to members was the proposed control over the use of specific medical devices commonly used in beauty procedures. The Administration's original proposal was to restrict the operation of Class 3B and Class 4 high-power medical laser to statutorily registered healthcare professionals; and allow only trained personnel who had passed the intense pulsed light trade test run by authorized institutes to operate intense pulsed light equipment if they were not statutorily registered healthcare professionals. Taking on board the Working Group's recommendation, the Administration would now engage an external consultant to conduct a more detailed study to examine overseas experience and practices of, and the scope of control on the use of, these medical devices. Noting that the study would aim to develop a set of criteria for determining the type of personnel and the level of competence required to operate specified types of devices, some members suggested that beauticians fulfilling a set of skills and competency requirements should be allowed to operate these devices when certain conditions were satisfied, say, they were working under the supervision of registered medical practitioners.

16. While pleased to note that an advisory committee comprising members from relevant stakeholder groups including trade associations, engineering institutions and academic institutes would be set up to advise DH on the classification of medical devices and issues relating to the implementation and administration of the future legislation, some members considered it necessary for the Administration to include also representatives from small and medium-sized medical device, beauty and optical traders, as well as frontline beauticians, in the advisory committee. The Panel would continue to follow up with the Administration on the matter in the next year when it would be briefed on on the outcome of the consultancy study and the details of the legislative proposal.

Regulation of pharmaceutical products

17. The Panel had examined in detail the Administration's legislative proposals to enhance the regulation of pharmaceutical products which aimed at implementing certain recommendations put forth by the Review Committee on the Regulation of Pharmaceutical Products in Hong Kong in its report issued in December 2009. Deputations were invited to give views on the legislative proposals at one meeting.

18. Members were particularly concerned that the Pharmacy and Poisons Ordinance (Cap. 138), which currently required a registered pharmacist to be present in an authorized seller of poisons ("ASP") for not less than two-thirds of its opening hours, would be amended to take effect at a later stage that the registered pharmacist concerned should be present whenever that ASP was opened for business. Members and the deputations which the Panel had met had expressed divergent views for the Administration's consideration. While some members supported the requirement for the sake of consumer protection and urged for its early implementation, some members took a different view that it was not an opportune time for introducing this amendment as there were insufficient manpower supply of registered pharmacists currently and in the near future and a lack of consensus support in the industry. They were concerned that its implementation would increase the operating cost of ASPs, in particular those in small and medium size, and might also result in ASPs being monopolized by large consortia. Upon review, the Administration had decided to leave out the proposal in the present exercise. Members supporting the proposal urged the Administration to formulate a timetable to reintroduce a future bill on the proposal.

19. Some members pointed out that many ASPs engaged not only in the retail sale of pharmaceutical products, but also a range of other daily goods, such as bottled water and infant milk formula. They held a strong view that at times when a registered pharmacist was not present at the part of the premises where poisons were kept for the purpose of retail sale, the rest of the premises should be allowed to remain open for sale of goods not classified as poisons. The Administration was also requested to take into account the concerns of members and deputations over the liability of a registered pharmacist in the event of non-compliance by the owner or other staff members of an ASP of the proposed requirement that all poisons listed in Part I of the Poisons List had to be stored in locked receptacles at the registered premises of an ASP with the key kept by the registered pharmacist; the disqualification of an ASP for repeated drug-related offence; and whether vitamin preparations should remain as a pharmaceutical product such that wholesalers of which would become

subject to the licensing and keeping of transaction records requirements in drafting the bill. The Administration introduced the Pharmacy and Poisons (Amendment) Bill 2014 into LegCo on 26 March 2014. A Bills Committee was formed to scrutinize the Bill.

Mental health policy and services

20. The Panel continued to attach great importance to ensuring that the mental health regime could meet the needs of the population. It had received a briefing from the Administration on the Review Committee on Mental Health's progress of reviewing the existing mental health policy and services. The Panel also received views from patient groups, service users, non-governmental organizations ("NGOs") providing mental health services, Equal Opportunities Commission and frontline social workers on the subject matter at another meeting.

21. Members continued to call on HA to provide evening services at its psychiatric specialist outpatient clinics, and the Administration to enhance support to mentally ill persons living in the community. Some members expressed grave concern over the increase in the number of cases of common mental disorders and the long waiting time for public psychiatric specialist outpatient services. They urged HA to shorten the waiting time for first appointment for urgent, semi-urgent and routine cases. Some members were concerned about the challenges to be brought about by a growing demand for psychogeriatic service in view of an ageing population.

22. Members shared the views of deputations that the existing mental health services fell far short of meeting the needs of mentally ill persons, ex-mentally ill persons and carers, and were of deep concern about the lack of close collaboration among various Government departments for service delivery. They were keen to ensure that the Administration would map out a blueprint and allocate adequate resources for the long-term development of mental health services. In some members' view, the Administration should go further to establish a mental health commission to provide advice to the Government in the formulation of a comprehensive policy in promoting mental well-being of the population while safeguarding the interest of those with mental illness. Some members stressed the need for the Administration to expedite its feasibility study on statutory community treatment order.

23. The Administration assured members that the Review Committee which adopted a life-course approach to the review was working in full swing. It had focused its initial efforts on examining adult mental health

issues. Its two expert groups were studying dementia care and mental health services for children and adolescents in parallel. The Panel requested the Administration to take heed of the various issues of concern raised by the deputations and revert on the work progress of the Review Committee in the next session.

Dental care policy and services

24. The dental care policy and services, in particular the dental care support for the elderly persons and people with disabilities, was of great concern to the Panel. Members expressed a strong view that the existing scope of public dental care service was far from adequate to meet the dental care needs of the vulnerable groups. Notwithstanding the Administration's repeated clarification that its policy on dental care would remain as raising public awareness of oral hygiene and oral health through promotion and education and provision of emergency dental services treatments, members asked the Administration to review the policy to meet the aspiration and needs of the community.

25. Members noted that there were currently some 2 000 registered dentists and there would be a supply of 50-odd local dentist graduates each year. There was concern about the adequacy of dentist manpower supply to improve the public dental care services. The Administration advised that it had commissioned a study to forecast the manpower demand and supply situation of the 13 healthcare professions under statutory regulation. Forecast for dentists was expected to be available towards the latter half of 2014. Having considered the findings from the study, the Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development would, among others, advise the Government on how to cope with anticipated demand for healthcare manpower.

26. Members also put forward a number of interim improvement measures for the consideration of the Administration, including providing elderly persons with separate vouchers for dental care services under the Elderly Health Care Voucher Pilot Scheme; providing outreach dental care services for residents of residential care homes for persons with disabilities; expanding the scope of primary dental care services to include annual oral check-up and other curative treatments such as scaling and fillings; and increasing the number of government dental clinics to cover all 18 districts in the territory.

Measures for the prevention and control of diseases

Multidrug Resistant Organisms

27. Members expressed grave concern about the increasing number of infections with Multidrug Resistant Organisms ("MDRO") reported in hospital and institutional settings, in particular the rising trend of Vancomycin Resistant Enterococcus ("VRE") carriers screened in public hospitals. Members considered it of paramount importance to prevent the outbreak of VRE in these settings during the current non-endemic window period. As explained by the Administration, MDRO transmitted mainly through the contaminated hands of healthcare workers who had contacted with an infected patient or contaminated areas in the patients' environment. Encouraging good hand hygiene practice among patients and healthcare workers and enhancing environmental decontamination were the most important steps to combat the emerging VRE problem.

28. Members noted with concern that nearly all VRE cases were asymptomatic carriers. They stressed that HA should strengthen its patient segregation and environmental decontamination measures in order to prevent the ongoing transmission of the bacteria in the hospital setting. Of equal concern to members was the infection control measures in private long-term care facilities. They urged the Administration to ensure the infection control capacity of private residential care homes for the elderly to receive VRE carriers discharged from hospitals. Members also suggested that efforts to promote among the public hand hygiene and awareness of antibiotic resistance should be stepped up.

Invasive pneumococcal disease

29. Two fatal cases of invasive pneumococcal disease ("IPD") caused by serotype 3 pneumococcus involving two young children, both with good past health, occurred in November 2013. In view of the wide public concern across the community, in particular those parents whose young children had not been immunized with pneumococcal conjugate vaccine ("PCV"), which conferred, among others, protection against serotype 3 pneumococcus, the Panel requested the Administration to brief members on its measures for the prevention and control of IPD.

30. While pleased to note the swift response of the Administration in planning to roll out in early December 2013 a childhood 13-valent PCV ("PCV13") booster vaccination programme to subsidize one booster dose for children aged two to under five years old who had never received PCV13, members expressed concern that the programme was at variance

with the decision of the joint meeting of the Scientific Committee on Vaccine Preventable Diseases and its Working Group on Pneumococcal Vaccination that a booster dose of PCV13 was not required at that point in time for children under five years old who had received 7-valent PCV or 10-valent PCV. Members urged the Administration to step up publicity on measures for the prevention of IPD and the effectiveness of PCV13 with a view to assisting parents of young children to make an informed vaccination decision. There was also a need to ensure that there would be sufficient vaccines for the programme and to meet local needs. Members also expressed the view that the Administration should continue to monitor the local trend of IPD and remain vigilant against the disease.

Human infections of avian influenza A(H7N9)

31. Hong Kong confirmed the first case of human infection with avian influenza A(H7N9) virus on 2 December 2013. The Government escalated the response level under the Preparedness Plan from "Alert" to "Serious" on the same day. The preparedness of the Government in case of an influenza pandemic was of great concern to the Panel. Given that the confirmed case was an imported case and had reported contact with poultry market on the Mainland, members called on the Administration to ensure that there would be sufficient manpower to carry out surveillance of inbound travellers having fever through temperature screening at all immigration control points, and cope with the additional workload arising from the enhanced laboratory testing for H7 avian influenza on live poultry from the Mainland and local farms as well as wild birds.

32. Members noted that the Administration had, on public health grounds, suspended the import of live poultry from the registered farms in Shenzhen since 3 December 2013. Some members suggested that the Administration should ban the import of live chicken from the Mainland in the longer term, as no surveillance system could attain zero risk and there had been a growing consumption of chilled and frozen chicken over the years. Some other members considered that this suggestion had far reaching implications. An alternative arrangement suggested by these members was to segregate the imported and local live chicken and hold the imported live chicken at a suitable location until the avian influenza testing results were available before releasing them to the wholesale market. Members also urged the Administration to seek the consent of the Mainland authorities on the early introduction of H7 serological test for live chickens imported from the Mainland with a view to reducing the avian influenza risks in Hong Kong.

Capital works and minor works projects of public hospitals

Redevelopment of Queen Mary Hospital (Phase 1) and refurbishment of Hong Kong Buddhist Hospital

33. The Panel examined the Administration's proposals on the preparatory works for the redevelopment of the Queen Mary Hospital (Phase 1) and refurbishment of the Hong Kong Buddhist Hospital. Members were supportive of both proposals which, in their views, would improve and enhance the facilities and service capacity of these hospitals. Many members stressed the need to ensure that clinical services of these hospitals would not be affected during the project periods. There was also a strong request from members for shortening the completion period of these two projects.

34. Members also considered it important for the Administration to enhance the overall capacity of the public healthcare system to meet the long-term medical needs of the community. The Administration advised that a number of public hospital development, redevelopment or expansion projects were now underway or in the pipeline. Members were assured that HA would regularly review the service capacity of its healthcare facilities taking into account factors such as the future population growth and demographic changes in different districts, the demand for healthcare services, the overall provision of healthcare services including service load and case complexity in the various clusters under HA, as well as the development of public and private partnerships.

One-off grant to HA for minor works projects

35. The Panel was consulted on the proposal to provide a one-off grant of $13 billion to HA for carrying out minor works projects, subject to a financial ceiling of $75 million for each individual item, over the coming 10 years or so. Whilst not objecting to provide additional financial resources to HA to improve its facilities and enhance its service capacity, some members considered that given the considerable amount of the proposed grant and the long span of time between now and 2023 or so, the proposal had violated the Administration's established fiscal discipline and went against its principle of prudent use of public money. Some members raised concern on whether it was an opportune time to provide a large amount of grant to HA when the comprehensive review conducted by the Hospital Authority Review Steering Committee on the operation of HA, which included, among others, its resource management system, was underway.

36. The Administration explained that the current annual funding arrangement under Subhead 8100MX for minor works projects had constrained HA's ability to flexibly plan and implement the necessary minor works projects for improving and maintaining the facilities in longer term. The proposed new arrangement would give HA more certainty of the funds available for a reasonably long period of time and accelerate the process of HA in planning and implementing the necessary minor works projects. Noting members' concern as to whether the monitoring role of LegCo in approving and monitoring the use of public money by HA would be diminished, the Administration assured members that it would be actively involved in the drawing up of the list of project items to be funded by the one-off grant, in particular those relating to capacity and service enhancement. The Administration had been asked to take into account members' views about the merits of individual project items when considering funding applications from HA and ensure that prioritization of the project items would be in the best interest of patients.

Issues relating to HA

Resources allocation among hospital clusters

37. The resources allocation among hospital clusters by HA was of considerable concern to the Panel. Members noted that HA would determine the resource allocation to each hospital cluster having taken into account the resources needed to sustain their baseline operations, additional resources required to deliver the new services, and any other resources needed to address specific pressure areas or gaps. There was a strong view among members that this mechanism had failed to align resources to areas of need. In some members' view, the crux of the problem was the long existence of fiefdoms and the uneven distribution of resources in terms of population ratio among the seven hospital clusters. Before the availability of a more fair mechanism for allocating resources across hospital clusters, they stressed the need for HA to allow patients to seek treatments in those hospital clusters with shorter waiting time if they wished to do so.

38. There were other suggestions from members that under the current medical manpower constraint, HA Head Office should flexibly deploy doctors among hospital clusters to address specific pressure areas, provide financial incentive to attract doctors to work in public hospitals located at remote areas, and allocate more funding to those hospital clusters having inadequate manpower so that they could incentivize their doctors to work extra service sessions and employ more part-time doctors. Members also called on the Administration to squarely address the problems relating to the management and cluster arrangement, resources allocation, human

resources management, service levels and overall cost effectiveness of HA through the Hospital Authority Review Steering Committee. The Panel would continue to follow up the subject matter when it would be briefed on the outcome of the review in the next session.

Surgical Outcomes Monitoring and Improvement Programme

39. The outcomes revealed by the Surgical Outcomes Monitoring and Improvement Programme Report of 2012-2013 as released by HA in January 2014, as well as HA's clinical governance and outcomes of two recent cases involving respectively a victim in the Manila incident and the temporary suspension of clinical rights of a doctor in performing certain cardiological interventions had aroused wide public concern. The Panel had requested a briefing from the Administration and HA on measures taken to monitor the clinical outcomes of HA at a special meeting.

40. Members were deeply concerned that the outcomes of the emergency surgeries performed by Prince of Wales Hospital and Queen Elizabeth Hospital during the period of July 2012 to June 2013 were statistically the worst among all public hospitals, and Tuen Mun Hospital was one of the top three worst performed public hospitals in both elective and emergency surgeries. They urged HA to identify the root causes and actively explore means for improvement. Some members surmised that heavy workload and insufficient medical manpower were two factors leading to the unsatisfactory performance of Tuen Mun Hospital. HA advised that it had found that high bed occupancy of surgical wards was inversely correlated with their outcomes. The differential utilization of Intensive Care Unit beds by patients who underwent elective and emergency operations might also have an impact on surgical outcomes. It would set up surgical high dependency units in these three hospitals in 2014-2015.

41. As regards the two recent cases of members' concern, HA assured members that all decisions regarding the timing and treatment modality of the victim in the Manila incident were made based on clinical needs. Separately, two expert panels and an Independent Review Committee had been set up to look into the case involving the temporary suspension of certain clinical rights of a doctor. The Independent Review Committee had received the reports from the two expert panels and were deliberating the findings. Upon completion, it would submit a report to the HA Board and recommend follow up actions as appropriate. The final outcome would also be made public when ready.

Public-private partnership initiatives on chronic disease management

42. The Panel had deliberated on HA's public-private partnership initiatives on chronic disease management, with reference to its Tin Shui Wai Primary Care Partnership Project and Public-Private Chronic Disease Management Shared Care Programme, as well as its proposal to launch the General Outpatient Clinic Public-Private Partnership Programme in Kwun Tong, Wong Tai Sin and Tuen Mun districts in mid-2014.

43. Concern was raised by some members as to whether the various public-private partnership 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. They stressed that any such initiatives should be no substitute for the public healthcare services which were provided to members of the public at highly subsidized rates.

44. Noting the arrangement that private doctors participating in the General Outpatient Clinic Public-Private Partnership Programme were required to bear the drug costs, there was concern that the level of subsidy might become the prime consideration of some doctors in prescribing drugs for the participating patients. HA advised that there was no cause for concern that the quality of treatment and medications provided by the 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. The arrangement to allow the doctors to decide whether to use the drugs listed for the Programme to be purchased from HA's drug suppliers at specified prices, 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 the doctors to adopt personalized care and treatment for individual patients.

Provision of cataract surgeries

45. The Panel continued to follow up the provision of cataract surgeries in HA. Of particular concern to members was the disparity between the notional waiting time of cataract surgeries among different hospital clusters. Noting that the waiting time in the Hong Kong West Cluster and Kowloon East Cluster had been shortened significantly since the establishment of two high volume cataract centres, some members suggested that more cataract centres should be established. According to HA, while there was a cross-cluster referral mechanism for patients on the cataract surgery waiting list to undertake surgery at hospitals having a

shorter waiting time, most of the elderly patients preferred to remain on the waiting list of the hospital clusters they belonged to. As undertaken by HA, it would establish more operation theatres in all hospital clusters to enhance the overall throughput of surgeries for patients.

46. Members urged the Administration and HA to allow more patients on the waiting list to join the Cataract Surgeries Programme to undertake surgeries in the private sector. They suggested that a higher level of subsidy should be provided under the Programme with a view to reducing the amount of co-payment required of the patients. There was a suggestion that for those hospital clusters with a long waiting list for cataract surgeries, HA should outsource the provision of cataract surgeries to patients on the waiting list to the private sector in order to thoroughly clear the backlog of cases.

Drug Formulary of HA and the Samaritan Fund

47. The Panel had long been deeply concerned about the financial burden imposed by the extremely expensive self-financed drugs on patients. Members were briefed that the governance in the management of the Drug Formulary of HA had been enhanced through the setting up of a high-level Drug Management Committee in 2013 to replace the former Drug Utilization Review Committee. The new Committee took charge of the Drug Formulary management at the strategic and policy level and oversaw the Drug Advisory Committee and the Drug Formulary Committee in carrying out their respective responsibility of appraising new drugs and reviewing the prevailing drug list of the Drug Formulary.

48. There was a strong view among members that efficacy should be the most important factor to be considered by HA in reviewing individual drugs. All drugs which were proven to be of significant benefits should be provided at standard fees and charges, rather than being classified as self-financed drugs with safety net. Some members urged HA to accord a higher priority to those drugs with same efficacy but fewer side effects.

49. Many members held the view that income of the extended family members living with the patients should not be counted as the patients' household income when assessing the financial condition of the applicants for the Samaritan Fund which acted as a safety net to subsidize the drug expenses of needy patients. Some members went further to suggest that patients living with their family members should be allowed to apply for assistance from the Samaritan Fund on an individual basis. According to the Administration, the practice of using patients' household income in assessing the level of subsidy granted under the Samaritan Fund was in line

with other safety nets funded by public money. Members were assured that due regard would be given to non-financial factors, such as medical and social grounds meriting special discretion, in the vetting process.

Injection to the AIDS Trust Fund

50. During the session, the Panel examined the Administration's proposal to inject $350 million into the AIDS Trust Fund ("ATF") in 2013-2014 to continue the support in prevention and control of Human Immunodeficiency Virus ("HIV")/Acquired Immunodeficiency Syndrome ("AIDS") in Hong Kong. Whilst supporting for the proposal, members called on ATF to accord higher priority to programmes targeted at high-risk groups identified by the Advisory Council on AIDS ("ACA"), in particular men who have sex with men. Some members raised concern about the effectiveness of existing HIV prevention interventions carried out by the ATF-funded NGOs in reaching the at-risk communities. The Administration advised that men who have sex with men was the highest priority community for HIV prevention. Given that at-risk populations were more receptive to HIV/AIDS-related services provided by NGOs, ATF played a crucial role in providing financial support to NGOs for the delivery of targeted preventions and surveillance to these populations.

51. In some members' view, the emphasis placed by ACA and ATF on the high-risk populations might give rise to the public misconception that only members of these populations would have the risk of contracting HIV. They considered that apart from supporting NGOs to encourage at-risk populations to reduce their risky behaviour, ATF should also promote condom use as a norm for safer sex in all sexual relationships. The Administration had also been asked to provide the up-to-date information collected by the ATF-funded NGOs on sexuality issues of the youth to the Curriculum Development Council's Committee on Personal, Social and Humanities Education for reference, so as to strengthen sex education to primary and secondary students.

Regulation of pesticide residue in Chinese herbal medicines

52. Arising from the media reports that a green group had conducted a test on samples of Chinese herbal medicines of Hong Kong and the Mainland in June 2013 and alleged that a high level of toxic pesticide residues was found in many of the Chinese herbal medicines tested, the Panel examined the Administration's work in regulating Chinese herbal medicines. Members were briefed that the test of the green group had made reference to the Maximum Residue Limits which reflected only the quality of food and was not an absolute standard for assessing the level of

food safety. If the safety reference values of Acceptable Daily Intake were taken as the testing standard, the pesticide residues as measured in their maximum human consumption quantity for the Chinese herbal medicines purchased in Hong Kong were below the limits.

53. Notwithstanding the Administration's explanation that a market surveillance system and an adverse events reporting mechanism were already in place to monitor the quality and safety of the Chinese herbal medicines regulated under the Chinese Medicine Ordinance (Cap. 549), members remained concern that the number of samples of Chinese herbal medicines collected by DH for testing, which stood at around 30 samples each month, was far from adequate for ensuring the safety of the Chinese herbal medicines sold in the market. Members also considered that the Administration should enhance the promotion of safe use of Chinese herbal medicines, say, the public should follow the instructions of the Chinese medicine practitioners when preparing decoctions of and consuming the medicines.

Health Protection Scheme

54. The Subcommittee on Health Protection Scheme established under the Panel in December 2012 continued to examine the voluntary Health Protection Scheme ("HPS") proposed under the Healthcare Reform Second Stage Public Consultation. The Subcommittee had held four meetings in the session to discuss with the Administration on the design of private health insurance policies regulated under HPS; public funding support for the implementation of HPS; supervisory framework for HPS; and strategic review on healthcare manpower planning and professional development, including the generic healthcare manpower forecasting model developed by The University of Hong Kong for the commissioned study on healthcare manpower planning and projection and a comparison of the regulatory framework in Hong Kong and that for healthcare professionals in overseas jurisdictions made by The Chinese University of Hong Kong for another commissioned study on regulatory framework for healthcare professionals. The Subcommittee would continue its work in the coming months when it would be briefed on the findings from the studies and the public consultation document on HPS.

Long-term care policy

55. The Joint Subcommittee on Long-term Care Policy established under the Panel and the Panel on Welfare Services in December 2012 continued to study the long-term care policy and services. In the session, the Joint Subcommittee had held nine meetings to discuss with the

Administration on various issues of concern including respite service for the elderly and persons with disabilities; care services for people with dementia; ageing problem of persons with intellectual disabilities; Integrated Home Care Services for the elderly; mental health case management; financial assistance on medications and medical or rehabilitation appliances; guardianship system for mentally incapacitated persons; quality and monitoring of private residential care homes for the elderly and for persons with disabilities; and hospice care services. The Joint Subcommittee would complete its work and provide a report to the Panels by end of July 2014.

Meetings and visit

56. From October 2013 to June 2014, the Panel held a total of 14 meetings. Another meeting has been scheduled for July 2014. The Panel had also paid a visit to the Hospital Authority Headquarters to observe a demonstration on the proposed Electronic Health Record Sharing System.

Council Business Division 2
Legislative Council Secretariat
2 July 2014

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 2013-2014 session

Chairman	Dr Hon LEUNG Ka-lau
Deputy Chairman	Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN
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, JP Hon CHAN Han-pan, JP 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 Maisie LAM
Legal adviser	Ms Wendy KAN
Date	2 July 2014