立法會
Legislative Council

LC Paper No. CB(2)1866/14-15
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 20 April 2015, at 4:30 pm
in Conference Room 3 of the Legislative Council Complex

Members present	**:**	Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon WONG Ting-kwong, SBS, JP Hon CHAN Kin-por, BBS, JP Hon Albert CHAN Wai-yip Hon YIU Si-wing Hon Charles Peter MOK, 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
Members absent	**:**	Hon Vincent FANG Kang, SBS, JP Hon CHEUNG Kwok-che Hon CHAN Han-pan, JP Hon Alice MAK Mei-kuen, JP Hon Christopher CHUNG Shu-kun, BBS, MH, JP
Public Officers attending	**:**	Item III Professor Sophia CHAN Siu-chee, JP Under Secretary for Food and Health

Mr LEE Yau-kwong
Principal Executive Officer (Health)
Food and Health Bureau

Dr Cindy LAI Kit-lim, JP
Deputy Director of Health

Mr Daniel WONG Kin-lok
Chief Treasury Accountant
Department of Health

Item IV

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

Miss Linda LEUNG
Principal Assistant Secretary for Food and Health (Health) 2

Dr Derrick AU
Director (Quality and Safety)
Hospital Authority

Dr T L LEE
Chief Manager (Quality and Standards)
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

Members noted that no information paper had been issued since the last meeting.

II. Items for discussion at the next meeting

[LC Paper Nos. CB(2)1237/14-15(01) and (02)]

2. Dr Helena WONG held the view that the Panel should discuss issues relating to the recent incident of a man impersonating a doctor in the United Christian Hospital. The Chairman suggested and members agreed that the subject "Security measures of the public hospitals of the Hospital Authority" be included in the agenda for the May regular meeting scheduled for 18 May 2015 at 4:30 pm. Members also agreed to discuss the following items proposed by the Administration at the meeting -

(a) Extension of Operating Theatre Block of Tuen Mun Hospital; and

(b) Progress of tobacco control measures.

3. Dr KWOK Ka-ki asked whether the Administration would report to the Panel on the progress of the review of mental health services for children and adolescents conducted by the Review Committee on Mental Health according to the schedule set out in the list of outstanding items for discussion by the Panel (i.e. in the first half of 2015). He considered it unsatisfactory that the Administration had dragged its feet in reverting to the Panel on the outcome of the relevant review. Under Secretary for Food and Health ("USFH") responded that the review was progressing in full swing. The Administration would advise after the meeting as to when it would be in a position to revert to the Panel on the review.

III. Revision of fees and charges for services not directly affecting people's livelihood under the purview of the Department of Health

[LC Paper No. CB(2)1237/14-15(03)]

4. USFH briefed members on the Administration's proposal to revise 118 statutory fee items ("the fee items") relating to the registration of healthcare professionals under the purview of the Department of Health ("DH"), details of which were set out in the Administration's paper (LC Paper No. CB(2)1237/14-15(03)).

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5. Noting that the cost recovery rate of the fee items after revision varied from less than 40% to over 90%, Dr KWOK Ka-ki asked whether the Administration would conduct another round of revision of the fees for registration of healthcare professionals sooner or later such that full cost recovery could be achieved. Citing the proposed revised fee for registration under the Dentists (Registration and Disciplinary Procedure) Regulations (Cap. 156A) (i.e. $2,170, at a cost recovery level of 67%) as an example, he was concerned that the fee levels might be too high for newly graduated healthcare professionals.

6. USFH advised that in line with the "user pays" principle, the fees and charges of Government services should in general be set at levels sufficient to recover the full cost of providing the services. The Financial Secretary had stressed in his 2013-2014 Budget Speech that the Government should adhere to the "user pays" principle. In proposing the adjustments, the Government would first deal with fees which had not been revised for years and did not directly affect people's livelihood, as well as items which had low cost recovery rates. In order to achieve full cost recovery gradually and avoid a steep fee increase, the guideline adopted in the current fee revision exercise was that those fee items with an existing cost recovery rate of less than 40%, between 40% to 70%, and over 70% would be increased by about 20%, 15% and 10% or less respectively. The fees for those items with an existing cost recovery rate of over 100% would be adjusted downwards to the full cost recovery level. The Administration would continue to regularly review the cost of the fee items and propose further revision as and when necessary under the "user-pays" principle.

7. Noting that these fees were last revised between 2000 and 2006, Mr POON Siu-ping asked whether the fee revision would take place regularly or whenever the cost recovery level of the fee items fell below 40%. USFH advised that except for 56 items which were covered in the last revision exercise in 2006, there had not been any revision for the fee items for years.

8. Dr KWOK Ka-ki asked whether DH had made any efforts to reduce and contain the costs of administering the registration of various healthcare professionals. Replying in the positive, Deputy Director of Health added that the costs of some of the fee items had been reduced in recent years as a result of streamlining of procedures. At the request of Dr KWOK Ka-ki,

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Deputy Director of Health undertook to provide in writing information on the calculation methodology of the costs of the fee items.

9. Dr Helena WONG noted from paragraph 9 of the Administration's paper that the existing calculation methodology for the cost of the Licensing

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Examination for medical practitioners would remain unchanged for the time being, with a view to avoiding increasing the fees to a prohibitively high level which would discourage eligible candidates from sitting the examination. She sought clarification about the reason why there was still an increase in the Licensing Examination fees in the current fee revision exercise as set out under items 28 to 31 in Annex A to the Administration's paper.

10. USFH explained that the proposed adjustments in the Licensing Examination fees for medical practitioners were worked out according to the existing computation methodology, under which only the cost incurred by the Medical Council Secretariat in arranging the examination, but not the relevant cost incurred by The University of Hong Kong and The Chinese University of Hong Kong in setting examination questions, providing examiners and testing candidates in hospital environment with patient participation, had been factored into the calculation of the full cost. This computation methodology would be reviewed in future when these examination fees had all been revised to a level close to the full recovery of the cost incurred by the Medical Council Secretariat.

11. Mr POON Siu-ping opined that the increase in the fees relating to the registration of healthcare professionals might indirectly affect people's livelihood, as some healthcare professionals in solo practice might transfer the additional cost incurred under registration to their customers. In response, USFH stressed that the proposed fee adjustments were mild (ranging from 7% to 20% and the amount of increase for around 60% of the fee items was less than $100) and therefore there should be no cause for concern. Dr Helena WONG asked whether any opposing views on the proposed fee revision had been received from the 12 regulatory bodies listed in Annex B to the Administration's paper. USFH advised that the regulatory bodies consulted generally had no objection to the proposed fee revision.

12. Mr POON Siu-ping sought information about the total number of items involving fees and charges of services provided by DH. Chief Treasury Accountant, DH advised that under the purview of DH, there were a total of 238 fee items not directly affecting people's livelihood, whereas the number of fee items affecting people's livelihood was around 200. Dr KWOK Ka-ki asked whether the Administration had any plan to revise those fees and charges which would affect people's livelihood, USFH replied in the negative.

IV. Cross-cluster referral arrangement for public specialist outpatient services of the Hospital Authority

[LC Paper Nos. CB(2)CB(2)1237/14-15(04) and (05)]

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13. USFH briefed members on the cross-cluster referral arrangement in specialist outpatient clinics ("SOPCs") and its effectiveness on waiting time management in the Hospital Authority ("HA"), details of which were set out in the Administration's paper (LC Paper No. CB(2)1237/14-15(04)).

14. Members noted the background brief entitled "Cross-cluster referral arrangement for public specialist outpatient services of the Hospital Authority" (LC Paper No. CB(2)1237/14-15(05) prepared by the Legislative Council Secretariat.

Cross-cluster referral arrangement in public SOPCs

15. Dr KWOK Ka-ki and Mr Albert HO sought clarification as to whether the centralized coordinated referral arrangement, which was piloted in the specialties of Ear, Nose and Throat, Gynaecology and Ophthalmology of selected clusters, was now extended to cover all specialties, with the exception of psychiatric service, and all clusters. Replying in the positive, USFH added that HA staff might, however, recommend patients who required community support and frequent follow-up treatments to seek medical care at SOPCs close to their residence in order to provide greater convenience to the patients and encourage compliance with treatment plan.

16. Mr POON Siu-ping asked about the timetable for extending the cross-cluster referral arrangement to cover the psychiatry specialty. Director (Quality & Safety), HA ("D(Q&S), HA") advised that given that patients with mental illness residing in the community, particularly those suffering from severe mental illness, required specialist-supported care in the community, it was important that any cross-cluster arrangement had to be designed and implemented carefully. The arrangement under examination by the Coordinating Committee of HA was to allow certain patients with common mental disorders in clusters with long waiting time the option to receive treatment in designated clusters with shorter waiting time. Subject to the discussion of the Committee, it was expected that the arrangement would be introduced in the second half of 2015 on a pilot basis.

17. Dr LEUNG Ka-lau asked whether patients had to book appointments at SOPCs of their choice through the SOPCs in the clusters where they were residing. D(Q&S), HA advised that to address the disparity in waiting time of the aforesaid specialties between clusters, the centrally coordinated referral mechanism to pair up clusters to allow patients in clusters with long waiting time the option to be seen in the clusters with shorter waiting time would be continued. This apart, all patients could now book appointments for first consultation directly at SOPCs in other clusters of their choices. To facilitate patients to make informed decisions on whether or not to pursue

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cross-cluster treatment, HA had uploaded the SOPC waiting time information for all eight major specialties (namely Ear, Nose and Throat, Gynaecology, Medicine, Ophthalmology, Orthopaedics & Traumatology ("ORT"), Paediatrics, Psychiatry and Surgery) on HA's website and displayed the relevant waiting time information in SOPCs. HA frontline staff was reminded of the need to accept new case bookings from patients of other clusters where appropriate.

18. Pointing out that many elderly persons and the underprivileged were not frequent users of the Internet, Mr YIU Si-wing suggested that HA should request frontline nurses responsible for screening referrals of new patients to proactively advise and assist patients on the cross-cluster arrangement. He asked whether HA would compile statistics on a breakdown of the number of cross-cluster cases by whether the booking was made on the advice of frontline staff or initiated by the patients themselves.

19. D(Q&S), HA advised that apart from displaying the waiting time information in SOPCs, frontline staff was given a general instruction to advise patients of the cross-cluster arrangement. Given that the measure had only been implemented for about two months, HA would keep in view the effectiveness of the current operational arrangement. An option was to issue a good practice guide in this regard for the reference of frontline staff.

20. Dr LEUNG Ka-lau considered that the sustainability of the new arrangement hinged on whether resources would be allocated to the clusters on the basis of their number of SOPC patients. In his view, additional resources should be provided to underpin those clusters with increasing service demand under the new arrangement, so as to ensure that those clusters originally with a shorter waiting time, and hence attracting more new case bookings from outside the cluster, would not become disadvantaged.

21. D(Q&S), HA said that HA took note of Dr LEUNG Ka-lau's concern. He advised that according to the experience of the last two months, the proportion of SOPC patients from other clusters had increased by less than 1.5% for all clusters, except for the Hong Kong East Cluster which recorded a higher increase of 2.5%. Based on the past statistics that there were about 100 000 new SOPC cases per year in each cluster, it was expected that the number of SOPC attendances from other clusters would increase by around 1 000 to 2 000 cases per year for each cluster. D(Q&S), HA added that other than the factor of waiting time, patients whose clinical conditions were triaged as routine cases might have other considerations when they chose a medical facility for treatment. For instance, patients residing in the New Territories West ("NTW") Cluster were more willing to seek consultation at Tuen Mun Hospital albeit its long waiting time. While Queen Mary

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Hospital had a shorter waiting time, many patients residing in the Hong Kong West Cluster instead chose to receive medical treatment at SOPCs in other clusters for the convenience of travelling to and from their work place.

22. Mr Albert HO noted with grave concern that while gynaecology patients with longer waiting time in the New Territories East ("NTE") Cluster were offered a referral option to the Hong Kong East Cluster under the centralized coordinated cross-cluster referral arrangement introduced in April 2013, the 90th percentile waiting time for new routine cases in the NTE Cluster still stood at 98 weeks in 2014-2015 (up to 31 December 2014). He asked whether patients had to wait for another two years for follow-up consultation. USFH responded that the waiting time for follow-up consultations would depend on the clinical conditions of individual patients.

Long-term measures to manage the waiting time at SOPCs

Enhancing public primary care services

23. Dr LEUNG Ka-lau said that according to his experience as a part-time consultant providing specialist outpatient services at HA, more than half of the SOPC new cases could be taken care of by family doctors. He asked whether HA had conducted any studies on the proportion of SOPC patients whose conditions could be dealt with at the primary care level with a view to assessing how the service demand at SOPC level could be better managed.

24. USFH advised that as part of its efforts to manage the waiting time at SOPCs, HA had set up Family Medicine specialist clinics as gatekeeper for SOPC and for follow up on patients triaged as routine cases. D(Q&S), HA advised that while HA had not conducted a study referred to by Dr LEUNG Ka-lau, the experience of individual specialties in treating certain diseases could serve as reference. For instance, the experience of the specialty of ORT suggested that about 10% to 20% of its patients suffering from low back pain could be managed at the Family Medicine specialist clinics and general outpatient clinics ("GOPCs"). It should, however, be noted that the willingness of the patients concerned had to be taken into account in so doing.

25. The Chairman asked whether there were any cases whereby patients of HA who previously received care at SOPCs had been referred to GOPCs for continuous follow-up. D(Q&S), HA advised that patients who received treatment at SOPCs and were clinically stable could be referred to GOPCs to follow up their conditions.

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Review on the demand for and supply of public specialist outpatient services

26. Pointing out that the low-income group and the underprivileged, particularly those who required frequent follow-up treatment and allied healthcare services (e.g. physiotherapy), were not willing to travel afar to SOPCs in other clusters, Dr KWOK Ka-ki opined that the cross-cluster referral arrangement was at its best an interim measure which could not address the root problems of long waiting time at SOPCs which were related to manpower shortage and service capacity of HA. Citing the large number of ORT new cases in most clusters as an example, he urged HA to study the service demand for each specialty and cluster, with a view to coming up with a comprehensive strategy to address the problem.

27. D(Q&S), HA advised that HA was reviewing the workload (including the number of outpatient attendances, the number of patient discharges and the number of operations) and manpower of those specialties having a long waiting time. For the ORT specialty, it was found that while there was no direct correlation between the factors of manpower strength and waiting time at SOPCs, the availability of extra specialist outpatient service sessions and the internal deployment of staff to cope with the inpatient and outpatient service needs might affect the waiting time at SOPCs in certain clusters. It was also worthy to note that due to ageing population, the overall demand for ORT services had been rising rapidly across clusters, with the 90th percentile waiting time of routine cases stood at more than 100 weeks in four clusters in 2014-2015 (up to 31 December 2014). HA would give due regard to the manpower requirement of the ORT specialty in meeting the anticipated surge in service demand when the overall manpower shortage problem improved in the future. D(Q&S), HA further advised that HA would separately monitor the demand for follow-up treatment involving allied healthcare services and radiological imaging services (e.g. Computed Tomography and Magnetic Resonance Imaging) in each cluster, and would introduce appropriate measures to cope with the demand in this regard as and when necessary.

28. Considering it unacceptable to require patients of HA to wait for more than 100 weeks for the ORT specialist outpatient services, Dr Helena WONG urged HA to set a pledge for the waiting time for routine cases to reduce the waiting time to a reasonable level.

29. USFH advised that HA had implemented the triage system for all new SOPC referrals to ensure that urgent conditions requiring early intervention were treated with priority. HA's targets were to maintain the median waiting time for cases in priority 1 (urgent) and priority 2 (semi-urgent) categories within two weeks and eight weeks respectively. HA insofar had been able to

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keep the median waiting time of priority 1 and priority 2 cases within this pledge. As regards the routine category which involved less severe and non-urgent patients, there was a disparity in waiting time among clusters. D(Q&S), HA supplemented that the manpower constraint in HA in recent years had made it difficult for HA to cope with the escalating demand. In some hospitals, the lack of physical space for clinic expansion was also a limiting factor. In the face of an ageing population, HA would conduct a comprehensive review to identify the bottleneck of each cluster, with a view to exploring measures to enhance the specialist outpatient service capacity of each cluster in the next three to five years.

Financial and manpower resources

30. Dr KWOK Ka-ki pointed out that Hong Kong's share of public health expenditure (under the Domestic Health Accounts of Hong Kong) in Gross Domestic Product, which was at 2.5%, was much lower than that of other developed countries which stood at 6% to 7%. In his view, the problem of long waiting time for services of HA was not only due to an uneven distribution of resources among hospital clusters, but also an inadequate allocation of resources for public health expenditure. He asked when the Steering Committee on Review of HA would complete its review. USFH advised that it was expected that the Steering Committee would put forth its recommendations in June 2015. The Administration would revert to the Panel on the outcomes of the review.

31. Dr Helena WONG considered the past decision to reduce the number of publicly-funded first-year-first-degree places in medicine due to economic downturn and hence a reduction in Government subvention to HA, which had resulted in a reduction of the number of local medical graduates from 310 in 2007, to 280 in 2010, and further down to 250 in 2011, a major factor causing the current medical manpower constraint in HA which had in effect limited the service capacity of its SOPCs. USFH advised that the medical manpower shortage problem would improve as the number of local medical graduates would start to go up to 320 in 2015 and to 420 in 2018.

32. Mr Albert HO said that the Democratic Party was of the view that HA should address the medical manpower constraint issues through employing more doctors trained overseas by way of limited registration, and re-employing locally retired doctors on part-time or contract terms with reasonable remuneration. Noting that the registration period of doctors employed under limited registration was limited to not exceeding one year and could only be renewed for another year, he considered that the relevant provisions of the Medical Registration Ordinance (Cap. 161) should be amended to provide greater flexibility.

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33. D(Q&S), HA advised that HA had actively approach the retired doctors for working part-time in HA and the response was so far positive. At present, there were more than 200 part-time doctors working in HA, representing some 80 full-time equivalent doctors. The pay package of part-time doctors was set on a proportional pro-rata basis to the equivalent full-time package as part-time doctors were not required to take up fractional overnight on-call duties. HA was reviewing the mode of re-employment of retired doctors and the retirement age for doctors. The Chairman requested HA to provide after the meeting information on the breakdown of the existing number of retired doctors employed by HA on contract terms or part-time basis by disciplines and ranks. D(Q&S), HA agreed.

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34. Mr Albert HO considered that the HA Head Office should flexibly deploy its medical manpower among clusters to cope with the operational needs of pressurized areas, such as the NTW Cluster where not many doctors were willing to work there. D(Q&S), HA advised that the newly recruited Resident Trainees were now required to work in pressurized specialties in addition to the specialties of their choice.

35. Dr Helena WONG urged HA to revert to the Panel on its medium to long-term improvement plan with a view to ensuring that the software and hardware of the public healthcare system could cope with the increasing specialist outpatient service demand such that the waiting time of new routine cases could be shortened to a reasonable level. The Chairman said that this might involve a wider issue which was one of the areas under review by the Steering Committee on Review of HA. The Administration had undertaken to revert to the Panel on the outcome of the review in due course. USFH advised that apart from the review of HA's operation, the Administration was conducting a strategic review on healthcare manpower planning and professional development covering 13 healthcare professions which were subject to statutory regulation.

36. There being no other business, the meeting ended at 6:21 pm.

Council Business Division 2
Legislative Council Secretariat
7 July 2015