立法會
Legislative Council

LC Paper No. CB(2)2076/15-16
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 20 June 2016, at 4:30 pm
in Conference Room 2 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 CHAN Kin-por, BBS, JP Hon CHEUNG Kwok-che Hon Albert CHAN Wai-yip Hon YIU Si-wing, BBS Hon CHAN Han-pan, JP Hon Alice MAK Mei-kuen, BBS, JP Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung Dr Hon Elizabeth QUAT, JP Hon POON Siu-ping, BBS, MH
Members absent	:	Hon Albert HO Chun-yan Hon Vincent FANG Kang, SBS, JP Hon WONG Ting-kwong, SBS, JP Dr Hon Helena WONG Pik-wan Hon Christopher CHUNG Shu-kun, BBS, MH, JP
Public Officers attending	:	Item II Dr KO Wing-man, BBS, JP Secretary for Food and Health Miss Linda LEUNG Principal Assistant Secretary for Food and Health (Health) 2

Mr FONG Ngai
Principal Assistant Secretary for Food & Health (Health) 3
Food and Health Bureau

Dr LEUNG Pak-yin, JP
Chief Executive
Hospital Authority

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

Dr Derrick AU
Director (Quality and Safety)
Hospital Authority

Dr Dominic TSANG, BBS
Chief Infection Control Officer
Hospital Authority

Item III

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

Miss Fiona CHAU Suet-mui
Principal Assistant Secretary for Food & Health (Health)1

Ms Wendy AU Wan-sze
Principal Assistant Secretary for Food & Health (Health) Special Duties 1

Dr Teresa LI Mun-pik
Assistant Director of Health (Family and Elderly Health Services)
Department of Health

Dr Joanna SO Shuk-kuen
Senior Medical & Health Officer (Health Care Voucher)
Department of Health

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

Staff in attendance : Ms Janet SHUM
Senior Council Secretary (2) 5

Miss LEE Wai-yan
Clerical Assistant (2) 5

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I. Information paper(s) issued since the last meeting
[LC Paper No. CB(2)1597/15-16(01)]

Members noted that a referral from the meeting between Legislative Council ("LegCo") Members and North District Council members on 14 May 2015 concerning issues relating to public healthcare service planning in the North District had been issued since the last meeting.

II. Progress report on the implementation of the recommendations of the Steering Committee on Review of Hospital Authority
[LC Paper Nos. CB(2)1740/15-16(01) to (03)]

2. Members noted the paper provided by the Administration (LC Paper No. CB(2)1740/15-16(01)) and the updated background brief prepared by the LegCo Secretariat (LC Paper No. CB(2)1740/15-16(02)) on the subject under discussion, and the information note on service for urgent testing for severe influenza cases provided by the Hospital Authority ("HA") prepared by the LegCo Secretariat (LC Paper No. CB(2)1740/15-16(03)).

Allocation of resources among hospital clusters

3. Dr KWOK Ka-ki urged HA to expedite the development of a refined population-based resource allocation model so as to address the long-standing problem of uneven distribution of resources, in terms of the population size, among hospital clusters. He considered that HA should take into account the median income of the population of the catchment districts and the provision of private healthcare services in individual hospital clusters in developing the model. Mr Albert CHAN expressed grave concern about under provision of hospital beds and resources, in terms of the population size, for Tuen Mun Hospital ("TMH") under the New Territories West ("NTW") Cluster over the years. He sought elaboration about the concrete measures to address the limitations of the existing resource allocation model. While expressing support for the implementation of the refined population-based resource allocation model within three years from the time the report of the Steering Committee on Review of HA ("the Steering Committee") was published,

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Dr Fernando CHEUNG was concerned that at present, resources allocated to the New Territories East ("NTE") Cluster were not commensurate with its catchment population size.

4. Secretary for Food and Health ("SFH") advised that the development of a refined population-based resource allocation model would first require to carve out from the population-based resources utilization analysis the tertiary and quaternary services provided by designated hospitals and other central clinical or support services not being provided across all clusters, such as the provision of liver transplant services in the Queen Mary Hospital ("QMH") for patients throughout the territory. The next target of HA was to work out the conceptual framework and methodology. As regards the enhancement of the clinical service capacity of the NTW Cluster, it should be noted that the works project to expand the operating theatre block of TMH, which was one of the projects under the 10-year hospital development plan of HA ("the 10-year plan"), had already commenced. Chief Executive, HA ("CE, HA") supplemented that as recommended by the Steering Committee, a time-limited funding of $300 million had been provided to HA for three financial years from 2015-2016 to 2017-2018 to address under provision problem of the Kowloon East ("KE"), NTE and NTW Clusters. The progress of implementing the catch-up plans would hinge on the increase in the number of local medical graduates and commencement of operation of relevant medical facilities in due course. To address the deficiencies in the service capacity of the NTW Cluster, 122 among the 250 additional beds opened in 2015-2016 and 109 among the 231 additional beds to be opened in 2016-2017 were in the NTW Cluster. This apart, the new Tin Shui Wai Hospital ("TSWH") was targeted to commence operation in 2016-2017.

5. In response to the Chairman's concern about whether there would be sufficient healthcare manpower for the commissioning of TSWH, CE, HA advised that the commissioning of the various services of TSWH would be in phases. For instance, the duration of service hour of the accident and emergency ("A&E") service at TSWH would initially be eight hours a day, to be extended to 12 and 24 hours in later phases subject to healthcare manpower availability. Mr Albert CHAN was of the view that the provision of designated services should not be focused on the two teaching hospitals. SFH advised that a high volume centre for joint replacement had been set up in the Pok Oi Hospital ("POH") under the NTW Cluster to provide one-stop service to patients.

6. Dr Fernando CHEUNG urged the Administration and HA to ensure transparency of both the formulation of the refined population-based resource allocation model, and the future allocation of resources under the model. SFH advised that the model to be developed by HA would take into account, among others, the resources required by individual clusters after taking into account the size and demographics of the population residing within its catchment

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districts, as well as the provision of designated services. CE, HA supplemented that HA had commissioned an external consultancy to help develop and validate the model. The consultant team had started work in April 2016. It was expected that a prototype would be formulated for further deliberation in HA Board by the third quarter of 2016. A consultation document would be published to engage and collect stakeholders' view by then.

7. Dr LEUNG Ka-lau was concerned about whether the 10-year plan could meet the service demand arising from a growing population of the two New Territories Clusters, as about half of the additional hospital beds (i.e. about 2 400 out of 5 000 hospital beds) would be provided at the new acute hospital in the Kai Tak Development Area ("KTDA"). In his view, more new public hospitals should be developed at the two New Territories Clusters. He sought information about how the ratio of hospital beds per 1 000 population of each hospital cluster would be improved under the 10-year plan.

8. SFH advised that the new acute hospital in KTDA would provide not only core hospital and clinic services to serve the population of the Kowloon Central Cluster (in particular the Wong Tai Sin population), but also designated services for patients throughout the territory. The Administration and HA had taken into account, among others, population growth of the catchment districts of each hospital cluster in planning for the public hospital development and expansion projects under the 10-year plan. In response to Dr KWOK Ka-ki's concern about whether the services of the Queen Elizabeth Hospital ("QEH") would be relocated to the new acute hospital in KTDA in future, SFH clarified that the plan of the Administration was to redevelop QEH in the longer term. A possibility being explored was to decant the clinical services of QEH to the new acute hospital in KTDA during the period of redevelopment, as in-situ redevelopment while maintaining the existing clinical services with minimum disruption would be more time-consuming.

Service management

Specialist outpatient services

9. Dr KWOK Ka-ki expressed concern that many patients were not aware of the availability of patient-initiated cross-cluster new case booking service at public specialist outpatient clinics ("SOPCs") for the major specialties of Ear, Nose and Throat; Gynaecology; Medicine; Ophthalmology; Orthopaedics and Traumatology; Paediatrics; Psychiatry; and Surgery. CE, HA responded that HA had displayed waiting time information for the specialties concerned in SOPCs to facilitate patients' understanding of the waiting time situation when considering whether to pursue cross-cluster treatment. HA would step up publicity on the service through, among others, frontline staff of HA.

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10. Mr CHAN Kin-por noted that HA would explore the use of family medicine specialist clinics to help attend to routine cases through Low Back Pain clinic so as to shorten the long waiting time in orthopaedics and traumatology SOPC. Given the increasing acceptance of chiropractic care by the public as revealed by a survey conducted by the Census and Statistics Department, he asked whether HA would consider tapping the capacity of chiropractors in the private sector to meet the service demand in this regard. SFH responded that while the Administration was open minded on the suggestion, there was no compelling scientific evidence so far supporting the cost-effectiveness of chiropractic care in treating low back pain.

11. Mr CHAN Kin-por asked about the measures put in place by HA to ensure that the surge in the number of patients with common mental disorder would not adversely affect the capacity of psychiatric SOPCs in managing patients with severe mental illness.

12. Director (Cluster Service), HA ("D(CS), HA") advised that with the majority of persons queuing up at SOPCs being common mental disorder cases, HA had enhanced the multi-disciplinary element in the service delivery model by engaging more trained psychiatric nurses and allied health professionals to provide active intervention for these patients under supervision of doctors. The new service delivery model had proved to be effective in improving treatment outcome and enabling early discharge of those cases who had satisfactorily completed the care plan developed by doctors, and hence, shortening the overall waiting time of new case booking for routine cases. The new service delivery model would be further piloted in the KE Cluster before extending to other hospital clusters as and when appropriate. The above apart, HA was in discussion with the Hong Kong Medical Association on the possibility of introducing a public-private partnership ("PPP") programme to refer suitable and stable patients to the private sector for continual medical follow-ups, so as to help relieve pressure on public psychiatric SOPCs.

Elective surgeries

13. Dr LEUNG Ka-lau suggested that HA could consider increasing the number of operating theatre sessions to allay the waiting list of elective surgeries by extending the regular operating hours of the operating theatres, which at present ended at 5:00 pm, to 9:00 pm. Given the current medical manpower constraint in public hospitals, HA could make reference to the average unit cost per operation for each elective surgery and engage doctors of the private sector to perform surgeries during the extended operating hours.

14. CE, HA advised that in addition to medical staff, nursing, allied health, pharmacy, radiological and supporting manpower was required to maintain the operation of operating theatres. HA would give due consideration to a basket

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of factors in deciding whether the demand for a particular service could be managed through collaboration with the private sector. At the present stage, it considered it more viable to implement PPP for those services that could be provided at the premises of the private healthcare service providers concerned. A case in point was the General Outpatient Clinic Public-Private Partnership Programme.

Service demand in the winter influenza season

15. Dr KWOK Ka-ki and Dr Fernando CHEUNG expressed grave concern about the long waiting time for inpatient admission to medical wards via the A&E Departments during the winter influenza season in 2016. Dr Fernando CHEUNG noted that HA had introduced a mobile application "PWH AE Aid" to provide patients with information on the real-time waiting status of the A&E Department of Prince of Wales Hospital ("PWH"). In his view, this could not help improve the waiting time for A&E services.

16. SFH advised that the long waiting time problem was partly caused by the lack of long-term healthcare infrastructure planning in the previous term Government to meet the rising service demand. The current term Government had already taken steps to increase the service capacity of the public health sector through the 10-year plan. D(CS), HA supplemented that HA planned to open 231 additional hospital beds in 2016-2017 to increase its service capacity. For the coming winter influenza season, HA would prepare its response plan in around August or September 2016. The step up measures to meet the surge in service demand would include, among others, further augment capacity through adding temporary beds in the existing medical wards as far as possible; enhance support to residents of the residential care homes for the elderly ("RCHEs") to reduce unnecessary admission; and facilitate transfer of stable patients from acute to convalescent hospitals within cluster to improve patient flow. CE, HA advised that where necessary, HA could brief the Panel on the response plan of HA to tackle the next winter surge in the 2016-2017 session.

17. Pointing out that residents of RCHEs were frail and at higher risk of admission, Dr Fernando CHEUNG urged HA to strengthen its collaboration with the Department of Health ("DH") and the welfare sector to provide a coordinated step-down care at the community level for minimizing the need of these elders for admission to hospitals during the influenza peak seasons. He was particularly concerned that since RCHEs were regulated by the Social Welfare Department ("SWD"), some RCHEs might consider it not necessary to take heed of the recommendations given by healthcare professionals of HA or DH's Centre for Health Protection on infection control measures to prevent outbreaks of influenza or other respiratory infections at the RCHEs concerned.

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18. SFH advised that there was established communication channel between the medical and welfare sectors on the provision of community care services for elderly patients. The relevant parties would look into the problem referred to by Dr Fernando CHEUNG as and when appropriate. CE, HA supplemented that efforts had recently been made by HA to better coordinate the outreach services provided by community geriatric assessment teams and community nurses to avoid overlap in service provision. Separately, HA had commissioned the Chinese University of Hong Kong to study measures to minimize the need for hospital admission via the A&E Departments for older patients. Measures being considered included conducting assessment of elderly patients presenting to the A&E Departments by designated staff (such as doctors or nurses providing community geriatric outreach services) so as to identify their admission need. At the suggestion of Dr Fernando CHEUNG, CE, HA agreed to monitor and where appropriate, follow up with DH and SWD if there were repeated admissions of a cluster of residents developing influenza-like illness from particular RCHEs.

19. Dr KWOK Ka-ki considered that the provision of urgent polymerase chain reaction test for influenza A and B outside office hours (i.e. from 5:00 pm to 9:00 am) at only the laboratories of PWH and QMH was far from adequate. Since it would take time for the delivery of samples from individual public hospitals to these two laboratories, he called on HA to designate more laboratories with 24 hours service for the provision of such services during the influenza peak seasons.

20. CE, HA assured members that the test results would be made available within eight to 12 hours. At present, the above two designated laboratories were able to cope with the demand for urgent testing outside office hours which was at a level of 10 to 15 tests per week. HA would keep in view the situation and assess whether there was a need to designate more laboratories to provide the service during the winter influenza season.

Staff management

21. Noting that HA planned to recruit 420 doctors, 1 720 nurses and 480 allied health professionals in 2016-2017 so as to increase its service capacity, Mr POON Siu-ping sought information about a breakdown of the numbers of new recruits by the manpower demand generated by turnover replacement and service growth. CE, HA undertook to provide the information in writing after the meeting.

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22. Referring to the central selection and appointment arrangement for specialty training of Resident Trainees, Mr YIU Si-wing was concerned about whether the arrangement would stall the recruitment process. Mr POON Siu-ping expressed a similar concern.

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23. SFH explained that there was a need to strike a right balance between central coordination and decentralization on the recruitment and deployment of staff of HA. The recommendation of the Steering Committee was to enhance the coordinating role of the HA Head office ("HAHO") in staff management, in particular the annual recruitment exercise of Resident Trainees and their placement to different specialities. The aim of the recommendation was not to revert to the other extreme of centralization like that during the pre-HA era where all personnel issues were in the single hand of the then Medical and Health Department, but to ensure greater consistency, fairness and parity in human resources practices at the cluster and hospital levels and minimize the perception of sectarianism under the past decentralized arrangement. D(CS), HA supplemented that enhancing the central coordination role of HAHO in the annual recruitment exercise of Resident Trainees and their placement to different specialties would on the one hand help to alleviate the workload of individual hospital departments in this regard, and on the other hand enable early planning to address manpower shortage in certain specialties where the staff turnover rate was high.

24. Mr POON Siu-ping asked how HA would enhance communication with the trade unions of various grades of staff. CE, HA advised that HA would regularly gauge staff's views and concerns on various issues through the established communication channels such as the Staff Group Consultative Committees and the HA Central Consultative Committee. It would also meet with various staff unions as and when necessary.

25. In response to Mr POON Siu-ping's enquiry about feedback from staff to the newly developed mobile applications on staff related functions which had been piloted for use at certain public hospitals since March 2016, CE, HA advised that the feedback was in general positive. Efforts would be made to improve the existing mobile applications to address the issue of arranging staff roster.

Management and organization structure

26. Dr KWOK Ka-ki queried the rationale for creating the position of Deputy Hospital Chief Executive ("HCE") for hospitals where the HCEs concerned had to manage more than one hospital.

27. CE, HA advised that on the recommendation of the Steering Committee, HA had, where appropriate, grouped two or more hospitals under the management of one HCE to bring the scope of duties of all HCEs to a comparable level. For instance, POH and the new TSWH would be headed under one HCE. The same applied to Our Lady of Maryknoll Hospital, Tung Wah Group of Hospitals Wong Tai Sin Hospital and Hong Kong Buddhist

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Hospital. The Deputy HCE appointment was a concurrent appointment where the incumbent needs to take up the role of Deputy HCE in addition to his or her current responsibilities. The Deputy HCEs who would be experienced frontline clinical or management staff of the hospitals concerned, would devote part of their time to assist HCEs in coordinating the clinical services and managing the daily operations of the hospitals. In response to Dr KWOK Ka-ki's further enquiry, CE, HA assured members that the clinical services provided by these clinical staff would not be affected.

Conclusion

28. In closing, the Chairman remarked that the next time the Administration updated the Panel on the progress of HA in implementing the recommendations of the Steering Committee in the 2016-2017 session, it should cover the impacts on the manpower requirement and resources allocation of HA, if any, to be brought about by the recommendations to be put forth by the Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development. SFH agreed.

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III. Review of the Elderly Health Assessment Pilot Programme

[LC Paper Nos. CB(2)1740/15-16(04) and (05)]

29. Under Secretary for Food and Health ("USFH") briefed members on the findings of the review of the Elderly Health Assessment Pilot Programme ("the Pilot Programme"), details of which were set out in the Administration's paper (LC Paper No. CB(2)1740/15-16(04)).

30. Members noted the background brief prepared by the LegCo Secretariat on the subject under discussion (LC Paper No. CB(2)1740/15-16(05)).

31. Dr KWOK Ka-ki considered the Pilot Programme unattractive to elders, as it only provided baseline health assessment but lacked long-term curative and clinical follow-ups. In addition, there were no service centres at some districts with a greater number of lower income groups. Noting that the Administration would cease to further pursue the Pilot Programme and given the ever-increasing demand for the primary health services provided by the Elderly Health Centres ("EHCs"), he asked whether more resources would be provided to increase the quotas of EHCs so as to shorten the waiting time for enrolment as new member of EHCs.

32. USFH advised that the distribution of the service centres depended on the NGOs participating in the Pilot Programme. It should be noted that the Pilot Programme had primarily met its objective of facilitating detection of previously unidentified health risks or problems, as 37% of the participating elders who had completed the baseline health assessment were newly identified

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to have at least one problem related to blood pressure, blood sugar, or blood lipid. Further analysis revealed that elders who lived alone, who did not have health assessment before, or who did not have regular follow-up by medical services ("hard-to-reach elders") might be able to benefit more from the Pilot Programme. The Department of Health ("DH") had critically reviewed the strategic direction of EHCs. It would implement a pilot collaborative model at EHCs with comparatively shorter waiting lists under which the EHCs concerned would collaborate with the non-governmental organizations ("NGOs") with elderly as their targeted clients to reach out to the hard-to-reach elders ("the pilot collaborative model"). Certain quotas would be reserved and priority would be given to the hard-to-reach elders identified and referred by social workers of the collaborating NGOs for receiving primary health services at EHCs. Separately, the Government would continue to seek additional resources to enhance the service capacity of EHCs, for example, by increasing the manpower. Two additional clinical teams for EHCs had already commenced operation in March 2015 and April 2016 respectively. However, owing to spatial constraint, there was difficulty to further enhance the service capacity of certain EHCs.

33. Noting that the Pilot Programme had met its objective of detecting participating elders' health problems which otherwise would remain undetected, Dr Fernando CHEUNG saw no reason why the Pilot Programme should not be further pursued when DH was still exploring how its elderly health assessment service could be enhanced through the measures proposed in paragraph 15 of the Administration's paper without any commitment on timetable and resources. The Chairman expressed a similar view, adding that the cost incurred by the Administration in conducting the Pilot Programme (i.e. a subsidy of $1,200 provided to NGOs for each elder and a co-payment of $100 contributed by each elder which could be met by the Elderly Health Care Voucher ("EHV")) was not high. Dr KWOK Ka-ki opined that alternatively, the Administration could subsidize elders to obtain low-cost health assessment services provided by the private sector. The fees charged by the private healthcare providers, which should be no more than around $300, could be met by EHV. Elders required clinical follow-ups could be referred to receive consultations at public SOPCs.

34. USFH explained that most of the participating NGOs considered it very challenging to implement the Pilot Programme, particularly in the areas of recruitment of the hard-to-reach elders, employment of suitable healthcare professions to provide the services, as well as high administrative, laboratory and manpower costs. Given that one of the key observations from the Pilot Programme was that health assessment had proven to be more effective in detecting health problems among the hard-to-reach elders, DH would, in collaboration with four District Elderly Community Centres or Neighbourhood Elderly Centres, first implement the pilot collaborative model in the Kwai

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Shing EHC. It was estimated that about 30 hard-to-reach elders identified and referred by the centres could receive primary health services each month at Kwai Shing EHC. Subject to the experience gained, the pilot collaborative model might be rolled out to other EHCs in phases.

35. USFH assured members that the Administration would strive to seek additional resources to enhance the service capacity of EHCs to better serve the growing elderly population. Being cognizant of the fact that EHCs alone could not meet the healthcare needs of all elders, the Government had taken steps to explore new models of service delivery, such as the EHV Scheme and the Community Health Centres. Assistant Director of Health (Family and Elderly Health Services), DH supplemented that around 31% and 6% of the first-time health assessment cases and subsequent health assessment cases of EHCs respectively had newly identified health problems. Hence, resources had been channelled into allocating more quotas to first-time health assessments for new members at all EHCs (i.e. from around 10% in 2013 to 37% in April 2016). With the implementation of the above and other measures as detailed in paragraph 12 of the Administration's paper, the median waiting time for enrolment as new members of EHC had been effectively shortened from 20 months in 2014 to nine months in April 2016.

36. Dr Fernando CHEUNG considered that the 30 monthly quotas under the pilot collaborative model were far from adequate. He urged the Administration to provide additional resources for the NGOs concerned for recruiting the hard-to-reach elders, rolling out the model to the other 17 EHCs and increasing the relevant quotas of EHCs for elders so identified. The Chairman remarked that given the limited annual EHV amount, elders seldom used vouchers for health assessment services at the private sector. He noted that although the Pilot Programme had achieved its objectives, the NGOs had difficulties in providing the required services, and the Government would deploy more resources to enhance EHCs.

IV. Any other business

37. This being the last meeting of the Panel in the current legislative session as well as in the Fifth LegCo, the Chairman thanked Panel members and the LegCo Secretariat for their contribution and support to the work of the Panel in the past years.

38. There being no other business, the meeting ended at 6:30 pm.

Council Business Division 2
Legislative Council Secretariat
27 September 2016