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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 2016-2017 session of the Legislative Council ("LegCo"). It will be tabled at the Council meeting of 12 July 2017 in accordance with Rule 77(14) of the Rules of Procedure of the Council.

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 medical and health services. The terms of reference of the Panel are in **Appendix I**.

3. The Panel comprises 24 members, with Prof Hon Joseph LEE Kok-long and Dr Hon Pierre CHAN elected as Chairman and Deputy Chairman respectively. The membership list of the Panel is in **Appendix II**.

Major work

Regulatory regime for medical devices

4. The roadmap of putting in place statutory regulation to govern the safety, performance, quality and efficacy of medical devices for the sake of public health has spanned over 15 years. Given the increase in the number of incidents involving unsafe medical devices and inappropriate use of such devices, coupled with growing public concern over the health risks of devices commonly used in beauty procedures, a major focus of the Panel during the

Fifth LegCo was the use control of medical devices under the proposed regulatory framework. Members were advised that given the heterogeneity of the devices involved, the Administration had commissioned an independent consultant in September 2015 to conduct a study on the control of use of selected medical devices which had been used for cosmetic purposes ("the study"). When the Administration briefed the Panel nearly a year later on the results of the study and its latest proposed regulatory framework for medical devices, members in general agreed with the broad direction of subjecting medical devices under regulation. Members, however, raised concern that the part of the proposed use control required further deliberation. Some members were of the view that use control should be imposed not solely on selected medical devices for cosmetic purposes, but on all types of medical devices which were used for different purposes, including, among others, home use, medical and cosmetic purposes. Of note was that according to the study, there might be no restriction on users of certain devices which, in some healthcare professions' views, were of high risk of serious injury or harm.

5. Noting that the devices being recommended under the study to require registered medical practitioners be stationed on site to supervise their use were commonly used by the beauty trade, some other members were concerned that the proposal would stifle the development of the beauty trade; affect the livelihood of the beauty practitioners, many of whom had already attained qualifications in respect of the use of various devices under the Qualifications Framework; and make the relevant beauty services become unaffordable to many members of the public. Interested parties were invited to give views on the subject at a special meeting of the Panel in February 2017. The Panel passed three motions at a subsequent meeting urging the Administration to, among others, revisit the proposed use control of specific medical devices and set up a multi-party platform to invite participation from different stakeholders to provide views on the subject. Having regard to members' views, the Administration advised that it would focus its efforts on taking forward the legislative proposals concerning the pre-market control and post-market control under the regulatory regime for medical devices, whereas the part on use control for selected medical devices would be revisited later.

6. To enable more focused discussion on the subject, the Panel and the Panel on Commerce and Industry agreed to appoint a joint subcommittee under the two Panels to study issues relating to the regulation of devices and development of the beauty industry and make timely recommendations. The joint subcommittee would commence work when a vacant slot became available to accommodate its activation.

Regulatory regime for private healthcare facilities

7. Following up its work in the Fifth LegCo, the Panel gave views on the proposed new piece of legislation for private healthcare facilities which was drawn up on the basis of the outcome of the public consultation on the subject conducted from December 2014 to March 2015. Members in general supported the proposed new regulatory regime for private healthcare facilities. Members were pleased to note that the Administration had taken heed of the majority view that the proposed two-tier complaints management system would cover not only private hospitals, but also day procedure centres, clinics and health services establishments to be regulated under the new regime. Some members raised concern on the proposed exemption arrangement for those clinics which involved only solo or small group practice, which would in effect exempt around 80% of the medical and/or dental clinics from regulation. Given the tight timeframe under the negative vetting procedure under section 34 of the Interpretation and General Clauses Ordinance (Cap. 1), there was a suggestion that any amendments in respect of the schedule on the medical procedures performed in day procedure centres to be made under the Bill should be subject to the positive vetting procedure under section 35 of the Ordinance. There was also a view that the regulatory standards for clinics, which would be promulgated in the form of codes of practice issued by the Director of Health ("DoH"), should not be pitched at such a high level that most clinics would find it difficult, if not impossible, to comply with.

8. The issue of price transparency of private hospitals had all long been of considerable concern to the Panel. Members were pleased to note that under the new regulatory regime, a private hospital needed to make available to the public information about the prices of chargeable items and services provided in the facility, as well as put in place a budget estimate system for patients and publish historical statistics on the fees and charges for treatments and procedures specified by DoH. Members were briefed that to try out these price transparency measures before they were put into implementation after the passage of the Bill, the Department of Health ("DH") had joined hands with the Hong Kong Private Hospitals Association to roll out a pilot programme for enhancing price transparency for private hospitals in October 2016. Members were supportive of the pilot programme, and put forward a number of suggestions for the consideration of the Administration to further enable consumers to make informed choices. At the suggestion of members, DH was in the course of developing a webpage to provide the list of common operations or procedures for provision of budget estimates, as well as enabling members of the public to have convenient access to the historical bill sizes statistics released by private hospitals on their respective websites.

9. The Administration introduced the Private Healthcare Facilities Bill into LegCo on 21 June 2017. A Bills Committee was formed to scrutinize the Bill.

Manpower and regulation of the healthcare professions

10. A sustainable healthcare system needs to be supported by adequate and quality healthcare professionals. This is particularly challenging when the population ages and there are rising expectations for healthcare services. Issues of manpower planning and professional development of the healthcare professions were featured in the two-stage public consultation conducted by the Administration in 2008 and 2010 respectively to take forward the healthcare reform. Another major focus of the Panel in the session was the recommendations on ways to meet the projected manpower demand for and foster professional development of the 13 healthcare professionals that were subject to statutory registration as put forth by the Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development ("the Steering Committee"), which had been the outcome of a long deliberation and review process that started in January 2012.

11. Members had long held the view that the existing service level of the public healthcare sector was far from adequate to meet the demand from the community due to healthcare manpower shortage. They were gravely concerned that an assumption of the manpower projection model was that the demand at the base year (i.e. 2015) was at an equilibrium. Future demand for the projection period up to 2030 was derived having regard to demographic changes and other relevant factors including externalities and policy interventions, to which only known and planned services and developments were incorporated. Members urged the Administration to provide the formula for the calculation and adjust the manpower projection having due regard to the need for service enhancement. Members were assured that the Administration would, on the basis of the recommendation of the Steering Committee, conduct manpower planning and projections for healthcare professions once every three years in step with the triennial planning cycle of the University Grants Committee. The next projection exercise would soon start in the second half of 2017 for the 2019-2020 to 2021-2022 triennium. Question was raised as to whether the Administration could commit to provide adequate subvention to the Hospital Authority ("HA") for recruiting all locally trained medical graduates during economic downturn. The Administration stressed that locally trained graduates would always be the primary source of manpower serving in the public sector.

12. Members were briefed, among others, that a finding of the Steering Committee was that there was a shortage of medical practitioners in the short to medium term. Since the training cycle of local medical practitioners, in particular specialists, was very long, one of the recommendations of the Steering Committee was that HA should continue to recruit non-locally trained medical practitioners through limited registration in order to ease its medical manpower shortage problem in the short term. On regulation of healthcare professionals, the Steering Committee recommended, among others, that the regulatory bodies concerned should set a minimum lay membership of 25% to enhance public accountability, and improve the mechanism for complaint investigation and disciplinary inquiry to ensure that complaint cases would be handled in a timely manner for the interest of both the public and the healthcare professionals concerned. At present, the majority of complaint cases were lodged with the Medical Council of Hong Kong ("the Medical Council").

13. Members were aware that the Administration had not waited until the release of these findings and recommendations of the Steering Committee before introducing amendments to the Medical Registration Ordinance (Cap. 161) and its subsidiary legislation to respond to the mounting public concerns over the transparency and efficiency of the Medical Council in complaint investigation and disciplinary inquiries and its lack of flexibility for the admission of non-locally trained medical practitioners. However, the Committee stage proceedings of the Medical Registration (Amendment) Bill 2016, being one of the most controversial bills dealt with by LegCo in the last legislative session, could not be completed before the Fifth LegCo stood prorogation on 16 July 2016. The Administration briefed the Panel in May 2017 on its latest legislative proposals to amend the Medical Registration Ordinance and three items of its subsidiary legislation. The latest legislative proposals included some of those proposals proposed in the lapsed Medical Registration (Amendment) Bill 2016 and some new proposals.

14. Members generally supported the legislative proposals, but raised concerns on certain issues, including the number of directly elected registered medical practitioner members in the Medical Council and the implication on professional autonomy, the requirements relating to the qualifications and experience of an assessor for sitting on the Preliminary Investigation Committees and Inquiry Panels of the Medical Council, the effectiveness of the proposal of extending the maximum term of limited registration and renewal of such registration in attracting more non-locally trained specialists to perform clinical and hospital work in HA, as well as the recruitment and monitoring mechanism put in place by HA on medical practitioners employed under limited registration.

15. The Administration introduced the Medical Registration (Amendment) Bill 2017 into LegCo on 7 June 2017. A Bills Committee was formed to scrutinize the Bill.

Control of tobacco and alcohol consumption

16. Tobacco and alcohol are among the top preventable causes of various non-communicable diseases and deaths. For the former, it is estimated that tobacco use is responsible for causing over 6 700 deaths a year in Hong Kong. After briefing the Panel on its proposal to increase the area of the health warning from covering at least 50% at present to at least 85% of the two largest surfaces of the packets or retail containers of the tobacco products concerned and increase the number of forms of health warning from six to 12 in May 2015, the Administration took a year and a half to hammer out the details of the legislative proposals. Members were briefed in December 2016 that the Administration would table the relevant amendment order, which was a piece of subsidiary legislation, in LegCo for negative vetting in the first quarter of 2017.

17. Members were of unanimous view that smoking was hazardous to health. Many members were supportive of the legislative proposals which, in their view, could give existing smokers and potential smokers first-hand information on the health hazards of smoking so as to encourage cessation and to discourage uptake. However, some members raised concern that the legislative proposals were formulated in the absence of regulatory impact assessment and local evidence-based analyses to ascertain the effectiveness of increasing the size of health warning in reducing smoking prevalence. Given that there would be limited space left on packets and retail containers of the tobacco products for the display of trademarks and branding, they considered that this might lead to intensification of illicit and counterfeit cigarette trade. The duration of the transitional period, and the technical difficulties faced by local agencies of cigar products and a local manufacturer of soft pack cigarettes to comply with the proposed new requirements were also of grave concern to some members.

18. The discussion between the Panel and the Administration on the legislative proposals spanned over four meetings held between December 2016 and March 2017, including a special meeting for receiving views from members of the public and the tobacco trade on the subject. Having considered members' views, the Administration had made some refinements to its legislative proposals. However, some members remained concerned over certain issues. The Panel passed two motions in March 2017, urging the

Administration to reduce the coverage of health warning on the retail containers of cigars to 60% and 90% of the area of the largest surfaces on the front and the back of the containers respectively; and to defer the introduction of the amended subsidiary legislation into LegCo to May 2017 or later, with a view to fully respecting Members' right and their constitutional role in respect of voting on any motion to amend the subsidiary legislation before the expiry of the scrutiny period. The Administration tabled the Smoking (Public Health) (Notices) (Amendment) Order 2017 at the LegCo meeting of 26 April 2017. The Subcommittee formed to scrutinize the subsidiary legislation has completed its work.

19. When comparing to tobacco control, the relatively less effort made by the Administration in minimizing alcohol-related harm has long been of concern to some members of the Panel. As pointed out by the World Health Organization ("WHO"), alcohol is the single biggest risk factor for deaths among young people aged 15 to 29 globally. The earlier a person engages in drinking, the greater the likelihood of alcoholism developing in the person's later life. Following the long standing call of these members for strengthening alcohol control, the Panel was consulted on the Administration's legislative proposals to prohibit the sale of intoxicating liquor from vending machines and the sale or supply of intoxicating liquor to minors in the course of business, and to impose a notice requirement for face-to-face distribution and notice and declaration requirements for remote distribution.

20. Members agreed that alcohol consumption would pose harm to child and youth development in particular. While most members saw no reason for not supporting the new requirements, which were on par with that under the existing tobacco control regime, there was concern over the enforceability of the legislative proposals. Of particular concern to members was that the checking by the frontline staff of the proof of identity of a purchaser or recipient of intoxicating liquor if in doubt would overburden the trade and might give rise to disputes between the above two parties. In the absence of both a licensing system for retailing premises offering the sale and supply of intoxicating liquor for off-premises consumption and active enforcement to achieve a deterrent effect, members cast doubt about the compliance with the proposed new requirements by these premises.

21. The Administration introduced the Dutiable Commodities (Amendment) Bill 2017 into LegCo on 21 June 2017. A Bills Committee has been formed to scrutinize the Bill.

Handling of medical incidents in public and private hospitals

22. Effective monitoring of the quality of clinical practice and managing sentinel events are essential to improving the quality of medical service and minimizing clinical risk. Given the grave public concern about the various medical incidents in public hospitals and private hospitals in late 2016 and in 2017, in particular the serious untoward event in April 2017 at the United Christian Hospital involving a medication error and the patient concerned had subsequently underwent two separate liver transplant surgeries, the Panel had requested a briefing from the Administration on the mechanisms for handling medical incidents in public and private hospitals. Members were gravely concerned that while it was required under HA's Sentinel and Serious Untoward Event Policy ("the Policy") that clusters or hospitals were required to report to HA Head Office through the Advance Incident Reporting System any medical incidents classified as sentinel events or serious untoward events within 24 hours of their identification, around 20% of the sentinel events were not so reported during the period between October 2007 and March 2017. The Administration advised that HA had set up an independent panel in May 2017 to conduct a comprehensive review of the Policy, including, among others, the reporting and disclosure mechanisms. It was expected that the independent panel would submit its report to the HA Board in about eight weeks' time. Noting that certain types of sentinel events had remained as the top categories of sentinel events reported by HA since 2007, albeit HA had implemented improvement measures identified by the relevant Root Cause Analysis Panels for these incidents, some members raised concern as to whether healthcare manpower constraint of HA was a factor attributing to this phenomenon.

23. Some members drew to the Administration's attention that some reportable sentinel events and serious untoward events occurred in private hospitals appeared to have not been reported to DH. They cast doubt about the effectiveness of the existing arrangement of setting out the requirements on the management of sentinel events and serious untoward events in a code of practice promulgated by DH for, among others, private hospitals. The Administration advised that under the proposed new regulatory regime for private healthcare facilities, DoH might by order suspend a facility service in or a licence for a private hospital for a period DoH considered appropriate if the private hospital concerned had contravened, among others, the relevant ordinance, a condition of the licence, a code of practice or a direction. It was proposed that private hospitals should establish a comprehensive sentinel events management system. They should be mandated to report to DH the activities, findings and recommendations in connection with such events as and when required.

Mental health policy and services

24. As stated by WHO, there is no health without mental health. Of equal concern to members in the session was whether the mental health regime of Hong Kong could meet the needs of a growing population living with different degrees of stress. The Panel discussed with the Administration and received views from deputations on the recommendations put forth by the Review Committee on Mental Health for the enhancement of the overall mental services in Hong Kong following the completion of the review which started in May 2013. Separately, the Panel held a joint meeting with the Panel on Welfare Services to discuss the mental health services and relevant welfare issues in light of an alleged arson incident at MTR train in February 2017 involving a person with mental illness residing in the community. While pleased to note that as announced by the Chief Executive in the 2017 Policy Address, a standing advisory committee would be set up to continue to monitor the implementation of the recommendations of the review and to follow up on mental health development in Hong Kong, members were disappointed that the mental health policy statement incorporated as a preamble to the Mental Health Review Report provided neither a vision nor any concrete measures with timetables and resources required to address existing and future service needs. The Panel passed two motions in May 2017, urging the Government to upgrading the standing advisory committee to be an interdepartmental steering committee under the steer of Chief Secretary for Administration, with, among others, families and carers of ex-mentally ill persons sitting on the committee, for the formulation and monitoring the implementation of a comprehensive mental health policy and relevant service plans.

25. Some members expressed concern over the view of the Review Committee that it was not appropriate to introduce community treatment order in Hong Kong at this moment to mandate a person with mental illness who met a specified criteria to follow a prescribed course of treatment while living in the community, non-compliance of which might cause the person to be recalled to a hospital for treatment. They urged the Administration to consider afresh the issue, having regard to the need to further safeguard the health and safety of persons with mental illness and others in the community. Members also continued to call on the relevant bureaux and departments to strengthen medical-social collaboration; review the case manager to patient ratio of HA's Case Management Programme in order to strengthen the personalized and intensive support provided for patients with severe mental illness residing in the community; identify permanent sites for all Integrated Community Centres for Mental Wellness subvented by the Social Welfare Department; increase the

provision of antipsychotic depot injections during non-office hours to facilitate patients in need; and encourage responsible and accurate depiction of mentally ill persons in the media to reduce stigma associated with mental illness. As undertaken by the Administration, it would revert to the Panel on the concrete proposals for the implementation of the recommendations put forward in the Mental Health Review Report.

Policy on rare diseases

26. Another focus of the Panel in the session was the Administration's policy on and drugs for rare diseases. At the Panel's request, the Research Office of the LegCo Secretariat had studied the support measures for rare disease patients provided by Australia, the European Union, Japan, South Korea, Taiwan and the United States, which had devised comprehensive medical care policies over the years to address issues faced by rare disease patients, to facilitate the Panel's follow-up with the Administration. The Panel had also received views from members of the public, in particular rare disease patients and their carers, on the subject on 11 April 2017. Members were deeply concerned that the Government had not established any official definition of rare diseases, nor had it set out any specific policy on provision of support for rare disease patients. Hence, there was delay in the time to diagnose rare diseases and a lack of a comprehensive patient registry to facilitate the provision of evidence-based treatments to patients. In addition, there was insufficient provision of support and social care services to patients and their carers. Of particular concern to members was that many drug treatments for rare diseases were ultra-expensive and were unaffordable for average patients. However, the number of patients receiving subsidies from the Government and HA to help cover the expenses on the medication was limited.

27. Members were advised that the Government and HA had proposed a new Community Care Fund ("CCF") programme to subsidize eligible patients to purchase ultra-expensive drugs (including drugs for treatment of uncommon disorders). It was proposed that Eculizumab, the drug for treating Paroxysmal Nocturnal Haemoglobinuria, should be firstly included in the programme for specific patients with high risks who might have serious complications. It was estimated that about 10 to 16 patients would apply for the proposed programme to use Eculizumab in the first 12 months. While welcoming the introduction of the proposed programme, members considered that it should be a regularized programme instead of a programme under CCF. The Panel passed a motion at the meeting urging the Government to immediately formulate a policy on rare diseases; establish an inter-departmental central committee on management of

rare diseases; and immediately earmark $500 million to set up a rare diseases drug subsidy fund to provide subsidies for patients suffering from rare diseases. The Panel also requested the Administration and HA to revert to members on the feasibility of introducing ultra-expensive drugs into the safety net of the Samaritan Fund or other funds having taken into account, among others, the operational experience of the proposed CCF programme. Separately, members extended their sorrow at the passing away of a patient suffered from Tuberous Sclerous Complex 12 days after making an oral representation to the Panel on the above occasion.

Public healthcare services provided by HA

Revision of the fee for accident and emergency services

28. Hong Kong has a dual-track healthcare system by which the public and private healthcare sectors complement each other. Being the safety net for the whole population, the public healthcare sector focuses its resources on four target service areas which include, among others, acute and emergency care and services for lower-income and under-privileged groups. Years after the revision of the fees and charges for Eligible Persons in late 2002 and early 2003, the HA Board endorsed in December 2016 the latest Fees and Charges Review Report which recommended that, among others, the fee for accident and emergency ("A&E") services should be increased from $100 to $220 having regard to the increased cost and the fee gap between the existing A&E fee and the median charge of private doctors, so as to encourage appropriate use of public hospital services by shaping health-seeking behaviour as well as resources prioritization. Members had requested a briefing from the Administration on its views on HA's fees and charges review.

29. Members were gravely concerned that the proposed level of increase in A&E charge would increase the financial burden of the general public in using the A&E services and might affect their accessibility to adequate medical care. Some members cast doubt on whether the proposed increase could encourage patients of semi-urgent and non-urgent cases to seek other appropriate services, so that priority could be given to urgent cases. Many members held the view that there should not be a substantial increase in A&E charge unless there was enhancement in the provision of public general outpatient services. The Panel passed two motions in January 2017 expressing the view that it was inappropriate for HA to substantially increase the fees for A&E service before improvement was made to its outpatient services, which included the provision of public outpatient services in the evenings and on Sundays and public holidays; and requesting the Government to add quota for the grass-root sector

under the General Outpatient Clinic Public-Private Partnership Programme so as to provide the low-income group with affordable healthcare services and help relieve the waiting time problem of A&E service.

30. Members requested the Administration to revert to the Panel on the proposed way forward having regard to, among others, the views expressed by members and the views to be received by HA during the stakeholder engagement exercise on its revision proposal. Members were advised in April 2017 that taking into account the feedback received, the Administration considered that it would be more appropriate to increase the fee for A&E service from $100 to $180, instead of $220 as recommended by HA. The revised fees and charges for various services of HA, including the A&E charge, have taken effect from 18 June 2017.

Drug management of HA

31. It is the Government's public healthcare policy to ensure that no one is denied adequate medical treatment due to lack of means. Given that drug treatment was an integral part of medical treatment, the Panel continued to attach great importance to ensuring access by patients of HA to drugs of proven safety and efficacy at standard fees and charges. Members called on HA to comprehensively review the principles underlying the development of the HA Drug Formulary ("the Formulary"), which had been put in place since 2005. In particular, HA should engage patient groups and relevant professionals outside HA in managing the Formulary; address the problem that the drug formularies of the medium-sized public hospitals were different from that of the leading hospitals; reduce the extent of drug wastage; improve the safe custody of dangerous drugs; and shorten the time required for investigating complaint cases related to drug quality. Referring to the value-for-money audit on HA's drug management as set out in Chapter 5 of Report No. 67 of the Director of Audit ("the Audit Report") published in October 2016, there was a concern that no investigation had been conducted on the management of HA who should be held responsible for the mismanagement. Members were advised that in response to the recommendations put forth in the Audit Report, HA had drawn up an action plan for implementation in phases within a year.

Inpatient Medication Order Entry system

32. The Panel was briefed on the progress of the implementation of the Inpatient Medication Order Entry ("IPMOE") system by HA. Members were pleased to note that the IPMOE system, which had been implemented in 12 acute public hospitals in five hospital clusters, had enhanced overall patient safety and improved efficiency of clinical care in the hospitals concerned.

However, some members raised concern that the system was not user friendly enough for frontline doctors and nurses. Noting that HA planned to roll out the IPMOE system to all acute public hospitals and non-acute public hospitals in phases by end of 2021-2022, members requested HA to carry out a comprehensive review of the IPMOE system to further enhance the system, in particular the function to provide timely alerts on patients' drug allergy and drug-drug interactions to avoid medication error. There was a view that the Administration should provide additional recurrent funding for HA to recruit additional clinical pharmacists to form an integral part of the patient care team in the inpatient setting for all specialties.

Public healthcare infrastructure

33. The Panel had deliberated on the commissioning of services of the new Tin Shui Wai Hospital, the fifth public hospital member of the New Territories West Cluster and the third public hospital providing A&E services in the Cluster. Members were particularly concerned that the A&E Department of the Hospital would only open eight hours from 8:00 am to 4:00 pm daily when it commenced operation on 15 March 2017, and the service hours would only be extended to 12 hours in the fourth quarter of 2017. Members urged the Administration and HA to provide round-the-clock A&E services, and commence the ambulatory care services and convalescent inpatient services of various specialties at Tin Shui Wai Hospital as early as practicable to meet the demand of the catchment population, in particular those living in the vicinity of Tin Shui Wai and help decongest the situation in Tuen Mun Hospital ("TMH") and Pok Oi Hospital.

34. The Chief Executive announced in the 2016 Policy Address the earmark of a total provision of $200 billion for the implementation of a 10-year public hospital development plan ("the Plan"). In this session, the Panel examined in detail three of the public hospital development projects under the Plan. They were the preparatory works for the proposed construction of a new acute hospital at the Kai Tak Development Area ("KTDA"), the preparatory works for the proposed redevelopment of Prince of Wales Hospital (phase 2) (stage 1), and the construction of an extension of the Operating Theatre Block of TMH.

35. Members were supportive of these projects which would meet the long-term rising demand for healthcare services and facilities from the growing and aging population in Kowloon, New Territories East and New Territories West respectively. Members were advised that HA planned to relocate the clinical services of Queen Elizabeth Hospital ("QEH") to the new acute hospital at KTDA, with a view to providing an opportunity for redevelopment of the

original QEH site according to the service needs of Hong Kong as a whole. They requested the Administration and HA to ensure that the above arrangement would be in the best interest of the residents in Kowloon. There was a view that the Administration should ride on the Plan to revisit the planning ratio of the number of parking spaces to the number of hospital beds. Concern was also raised about the use of the dedicated provision of $200 billion under the Plan.

Implementation of the Voluntary Health Insurance Scheme

36. To enhance the sustainability of Hong Kong's dual-track healthcare system, it is of utmost importance to recalibrate the balance of the public and private healthcare sectors. The Government published the Consultation Document on Voluntary Health Insurance Scheme on 15 December 2014, in which a regulatory regime for individual indemnity hospital insurance was put forth for public consultation. It was proposed that all such products had to comply with a set of 12 Minimum Requirements prescribed by the Government to facilitate and encourage more people to make use of private healthcare services. This, in turn, would allow the public healthcare sector to focus on servicing its target areas. The Panel had followed up with the Administration on the views gauged during the public consultation exercise which ended on 16 April 2015, as well as the way forward for implementing the proposed Voluntary Health Insurance Scheme ("VHIS").

37. Many members expressed disappointment that while the proposal of establishing a High Risk Pool ("HRP") under VHIS, which was a key enabler of the Minimum Requirement of guaranteed acceptance, had been a feature put forth by the Administration for VHIS for years, the Administration would now re-examine the proposal and adopt a phased approach by launching a VHIS with 10 Minimum Requirements only. In addition, the latest proposal of the Administration was that VHIS would be implemented through a non-legislative framework, and it was still legally permissible for insurers to issue and sell non-compliant individual hospital insurance products in the market. These members doubted the effectiveness of VHIS in achieving its aim of redressing the balance of the public-private healthcare sectors in these circumstances. The Administration stressed that the Government had not abandoned the HRP proposal but would deal with it at a later stage. An early implementation of the 10 Minimum Requirements could address the existing shortcomings in market practices and hence, enhance quality of health insurance protection. It was expected that the VHIS practice guidelines and details of the tax deduction arrangement for VHIS-compliant products would be finalized for implementation in 2018.

Chinese medicines

38. Another focus of the Panel in the session was the mechanism put in place to ensure the quality of Chinese herbal medicines and proprietary Chinese medicines sold and supplied in local market. The Administration briefed the Panel in February 2017 on its legislative proposals to amend the Chinese Medicine Ordinance (Cap. 549) to empower DoH to prohibit the sale of Chinese medicines or related products in specified circumstances, or to recall such products in specified circumstances. Members supported the legislative proposals, but raised concerns on the operation details of the recall order, including the grounds on which such order would be made; the time to be given for the Chinese medicines traders to recall the products concerned; level of the penalty for failing or refusing to comply with the order; and the right to appeal against the order. Members requested the Administration to increase the number of samples of Chinese herbal medicines drawn from the market for testing of pesticide residues and heavy metals contents in tandem with the conferring of power upon DoH for making a recall order under the Ordinance. The Panel passed a motion at its meeting on 28 February 2017 urging the Administration to take into account the concerns of the trade in drafting the legislative proposal. In particular, the Director should provide sufficient time for the trade to recall the products concerned; specify clearly what constituted a recall, to the extent reasonably possible, of those products already supplied; and lower the maximum penalty for non-compliance, which was proposed to be a fine at level 6 (i.e. $100,000) and imprisonment for two years, to an appropriate level.

39. The Administration advised that it had conducted a meeting with the Chinese medicines traders associations and briefing sessions for individual licensed Chinese medicines traders to facilitate the trade to better understand the legislative proposals. A public consultation on the legislative proposal had also been conducted from January to February 2017. The public and the trade supported the proposal. The Administration introduced the Chinese Medicine (Amendment) Bill 2017 into LegCo on 14 June 2017. A Bills Committee was formed to scrutinize the Bill.

40. Separately, members were concerned about the short, medium and long-term strategy for the development of Chinese medicine in Hong Kong, including the registration of Chinese medical practitioners and Chinese medicines. To enable more focused discussion on the subject, the Panel appointed 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.

Marketing of formula milk and related products, and food products for infants and young children

41. WHO has emphasized for years the importance of maintaining the practice of breastfeeding for the well-being of mothers and children. In the session, the Panel gave views on the Administration's latest draft of the Hong Kong Code of Marketing of Formula Milk and Related Products, and Food Products for Infants & Young Children ("the Hong Kong Code"), which provided guidelines to local and overseas manufacturers and distributors of designated products for infants and young children aged 36 months or below, as well as the healthcare sector on the marketing of such products in Hong Kong. Interested parties were invited to give views on the subject at a special meeting of the Panel.

42. Some members agreed that there was a need to impose restrictions on formula milk for infants and that for young children. Some other members stressed the need to narrow down the scope of restrictions to the effect that they would only be applied to formula milk for infants less than six months of age, or at the very least not be applied to formula milk for young children beyond 12 months of age, same as the practice adopted by many developed countries or places. They raised question as to whether certain provisions of the Hong Kong Code would be of competition concern. Given that the Hong Kong Code would be implemented only in the form of voluntary guidelines and would not be backed up by any sanctions, there was a concern about the compliance of the traders with the requirements. There were views that the Administration should make public the names of those parties which failed to comply with the Hong Kong Code, or went further to make the implementation of the Hong Kong Code mandatory. According to the Administration, it would evaluate the effectiveness of the Hong Kong Code before considering the way forward, including whether legislation should be pursued. Members were subsequently advised that the Hong Kong Code had been launched on 13 June 2017.

Preparation for winter surge

43. Seasonal influenza, in particular influenza winter surge, would affect large segments of the community and had posed a recurrent challenge to the A&E departments and medical, orthopaedics and paediactrics wards of public hospitals. The preparatory work carried out by the Administration and HA each year to tackle influenza winter surge was of considerable concern to the

Panel. While pleased to note that the 2016-2017 Vaccination Subsidy Scheme ("VSS") had expanded to cover, among others, children aged six to under 12 years or attending a primary school in Hong Kong, members were concerned that the recommendations made by the Scientific Committee on Vaccine Preventable Diseases on the priority groups for the 2016-2017 seasonal influenza vaccination had not been fully taken heed of by the Administration in mapping out the target population groups for subsidized vaccination. There was also room for improvement on the arrangement of outreach vaccination activities under VSS for primary school students to receive seasonal influenza vaccination in schools by enrolled private doctors. On the opening of some 500 temporary beds in public hospitals in the 2016-2017 winter surge period, some members raised concern as to whether the additional hospital beds would be allocated to the most pressurized areas of HA during the winter surge period to meet the service demand growth. There was a call that the capacity of HA's designated laboratories with 24 hours services should be enhanced to facilitate timely clinical treatment.

Development of the stage two Electronic Health Record Programme

44. As part of the healthcare service reform proposed in 2008, the Government launched a two-stage Electronic Health Record Programme to develop an Electronic Health Record Sharing System ("eHRSS") to enable two-way health data sharing between public and private healthcare providers subject to patients' consent. The eHRSS developed under the stage one of the Programme commenced operation on 13 March 2016. The Panel was consulted on the Administration's proposal of increasing the commitment for the Programme for implementing the stage two of the Programme. Members were advised that as of December 2016, over 330 000 patients and 1 100 private healthcare providers had registered in eHRSS. Members were in support of the development of the stage two eHRSS, in particular its targets to cover data sharing of Chinese medicine information and sharing of visualized radiological investigation results. They urged the Administration to expedite the completion of the component-project of Patient Portal to enable patients' access to some key health data kept in eHRSS and facilitate patients' management of their eHRSS registration and related matters. There was also a view that the Administration should conduct an open public engagement exercise in the course of developing the stage two eHRSS.

Subcommittee in operation under the Panel

45. The Joint Subcommittee on Long-term Care Policy established under the Panel and the Panel on Welfare Services in November 2016 studied the

long-term care policy and services, including home-based, community-based and residential care services for the elderly, people with disabilities and the chronically. The Subcommittee had held seven meetings to discuss with the Administration various issues of concern including the review of Integrated Home Care Services; the Pilot Scheme on Residential Care Service Voucher for the Elderly; support for persons suffering from dementia and their family members; dental care for the elderly and people with disabilities; community support services for mentally ill and ex-mentally ill persons; and service quality of private residential care homes. The Subcommittee has scheduled another meeting in July 2017.

Meetings and visit

46. During the period between October 2016 and early July 2017, the Panel held a total of 19 meetings, including two joint Panel meetings with the Panel on Welfare Services. The Panel has scheduled another meeting in mid-July 2017 to discuss the Hong Kong Strategy and Action Plan on Antimicrobial Resistance, enhancement of medical fee waiver system of HA, and provision of public dental care services. The Panel also paid a visit to the Caritas Harold Lee Care and Attention Home in February 2017 to better understand the use of eHRSS.

Council Business Division 2
Legislative Council Secretariat
5 July 2017

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 the 2016-2017 session*

Chairman	Prof Hon Joseph LEE Kok-long, SBS, JP
Deputy Chairman	Dr Hon Pierre CHAN
Members	Hon Tommy CHEUNG Yu-yan, GBS, JP Hon WONG Ting-kwong, GBS, JP Hon CHAN Kin-por, GBS, JP Hon Mrs Regina IP LAU Suk-yee, GBS, JP Hon Paul TSE Wai-chun, JP Hon LEUNG Kwok-hung Hon YIU Si-wing, BBS Hon Charles Peter MOK, JP Hon CHAN Chi-chuen 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 Helena WONG Pik-wan Dr Hon Elizabeth QUAT, BBS, JP Hon POON Siu-ping, BBS, MH Hon CHU Hoi-dick Dr Hon Junius HO Kwan-yiu, JP Hon SHIU Ka-fai Hon SHIU Ka-chun Hon YUNG Hoi-yan Hon Jeremy TAM Man-ho (Total : 24 members)
Clerk	Ms Maisie LAM
Legal adviser	Ms Wendy KAN

* Changes in membership are shown in Annex.

Annex to Appendix II

Panel on Health Services

Changes in membership

Member	**Relevant date**
Hon Kenneth LEUNG	Up to 25 October 2016
Hon MA Fung-kwok, SBS, JP	Up to 7 November 2016
Hon Claudia MO	Up to 9 November 2016
Hon LAM Cheuk-ting	Up to 14 November 2016
Hon LEUNG Yiu-chung	Up to 14 November 2016
Dr Hon LAU Siu-lai	Up to 17 November 2016
Hon Andrew WAN Siu-kin	Up to 17 November 2016
Hon IP Kin-yuen	Up to 20 November 2016
Hon Dennis KWOK Wing-hang	Up to 20 November 2016
Hon Alvin YEUNG	Up to 29 November 2016
Hon Wilson OR Chong-shing, MH	Up to 7 December 2016
Dr Hon YIU Chung-yim	Up to 13 December 2016
Hon WU Chi-wai, MH	Up to 27 December 2016
Hon Tanya CHAN	Up to 2 January 2017
Hon KWONG Chun-yu	Up to 8 January 2017
Hon Nathan LAW Kwun-chung	Up to 25 January 2017
Hon James TO Kun-sun	Up to 5 February 2017
Hon HUI Chi-fung	Up to 7 February 2017
Hon Mrs Regina IP LAU Suk-yee, GBS, JP	Since 20 March 2017