A. Introduction

The Audit Commission ("Audit") conducted a review of the Department of Health ("DH")'s regulatory control of private hospitals with focus on the following areas:

- inspection of private hospitals;
- monitoring of sentinel events and complaints;
- price transparency in hospital charges; and
- performance measurement and reporting.

2. **Hon Abraham SHEK Lai-him** declared that he was currently a member of the Court and Council of the University of Hong Kong, and an Independent Non-executive Director ("INED") of Hsin Chong Construction Group Ltd. and NWS Holdings Limited (Hip Hing Construction Co., Ltd. is a subsidiary of NWS Holdings Limited). **Hon Abraham SHEK Lai-him** said that being an INED of Hsin Chong Construction Group Ltd. and NWS Holdings Limited, he was not informed of the April 2012 tendering exercise for private hospital development at two government sites. **Hon Abraham SHEK Lai-him** also said that being a member of the Council of the University of Hong Kong, he was aware that the University of Hong Kong might involve in the April 2012 tendering exercise for private hospital development at two government sites.

3. **Hon Paul TSE Wai-chun** declared that he was currently a member of the Court of the University of Hong Kong. **Hon Paul TSE Wai-chun** said that he was neither informed of nor involved in the April 2012 tendering exercise for private hospital development at two government sites.

4. **Dr KO Wing-man**, the **Secretary for Food and Health**, declared that before assuming the office of the Secretary for Food and Health on 1 July 2012, he had practiced in some of the private hospitals covered in the Audit Report as a registered medical practitioner.

5. The **Secretary for Food and Health** said in his opening statement that:

- under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) ("the Ordinance"), private hospitals in Hong Kong were subject to the regulation of the DH on matters relating to accommodation, staffing and equipment;

- in addition to the existing statutory regulatory control, the DH issued in 2003 a Code of Practice ("COP") setting out the standards of good practice regarding private hospitals' governance, quality management, patient care, risk management, clinical standards and so forth. Compliance with these requirements was a condition for the registration and re-registration of private hospitals;

- the last major amendments made to the Ordinance took place in the 1960s. In the past few years, there had been substantial changes in the ecology of the healthcare market, and there were also considerable concerns in the community about the safety, quality and price transparency of private hospital services; and

- the Government had, in October 2012, established a Steering Committee on Review of the Regulation of Private Healthcare Facilities ("Steering Committee") to conduct a review on the regulatory regime for private healthcare facilities including private hospitals.

The full text of the Secretary for Food and Health's opening statement is in ***Appendix 18***.

6. The Committee noted from paragraphs 6.2 and 6.4 of the Director of Audit's Report ("the Audit Report") that the DH had completed in December 2000 a review of the legislation, including the Ordinance, regulating private hospitals and other healthcare institutions ("the 2000 Review"). Pursuant to the 2000 Review, the DH considered that there was a need to introduce major changes to the regulation of healthcare institutions in terms of scope and regulatory standards. Nonetheless, the review of the Ordinance was subsequently held in abeyance. Against this background and in view of the rapid development of private hospitals in recent years, the Committee questioned why the Government had not introduced any legislative amendments to the Ordinance in the past years.

7. The **Secretary for Food and Health** explained that:

- since the establishment of the Hospital Authority ("HA") in 1990, the Administration had focused on the reform of the public health care sector in respect to its quality, cost-effectiveness and efficiency;

- subsequent to the study on "Improving Hong Kong's health care system: why and for whom" by the Harvard team in 1999, the financial sustainability of Hong Kong's health care system was accorded a high priority in the government policies;

- the Asian financial crisis in 1997 and the outbreak of SARS in 2003 had hampered the utilization and hence development of medical and healthcare services provided by private hospitals. Taking into consideration the then business environment and financial burden of private hospitals, it would pose further challenges to both the then Administration and private hospitals if any regulatory control of private hospitals were to be tightened; and

- although the review of the Ordinance had been held in abeyance after the 2000 Review, the then Secretary for Health, Welfare and Food had directed that a COP be developed in 2003-2004, enabling the DH to keep a close monitoring on the registered healthcare institutions.

8. The **Secretary for Food and Health** further said that the Steering Committee would come up with more practical and specific guidelines when it finished the review of the regulatory regime for private healthcare facilities including the private hospitals within a year. He assured the Committee that the DH would take on board the recommendations of the Steering Committee to strengthen the regulatory control of private hospitals so as to provide greater assurance to those who preferred and could afford to use private healthcare services. A press release issued by the Government regarding appointments to the Working Group on Regulation of Private Hospitals on 18 December 2012 is in ***Appendix 19***.

B. Inspection of private hospitals

Department of Health's inspection programme

9. The Committee noted from paragraph 2.3 of the Audit Report that the Office for Registration of Healthcare Institutions ("ORHI") of the DH was responsible for enforcing the Ordinance and the COP. The Committee asked how the ORHI of the DH carried out its function of regulating private hospitals.

10. **Dr Constance CHAN Hon-yee**, the **Director of Health**, said and elaborated in her letters of 21 and 28 November 2012 (in ***Appendices 20 and 21***) that:

- to ensure that the requirements set out in the COP were met, registered healthcare institutions were subject to at least an annual and an ad hoc inspections by the inspection team of the ORHI during a year;

- the ORHI staff conducted inspections of private hospitals according to the "Protocol for Inspection of Private Hospitals, Nursing Homes and Maternity Homes under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) (March 2010)" ("the Protocol");

- prior to the annual inspections, private hospitals were required to submit a completed Report for Registration in the form of a questionnaire demonstrating their compliance with the requirements set out in the COP;

- the ORHI staff would study the completed Report for Registration of each hospital and devise an inspection plan to cover various service areas of the hospital;

- the ORHI inspection team would follow the inspection plan to conduct on-site inspection and exercise their professional judgment to determine whether the quality of services was up to the requirements of the COP; and

- in case there was any serious irregularity found during the inspection, a regulatory letter would be issued to the hospital concerned and the ORHI would also follow-up with the hospital concerned to ensure rectification of any irregularities detected.

11. According to paragraph 2.7 of the Audit Report, the ORHI had previously used an inspection checklist for the annual inspections conducted in 2009 and for the ad hoc inspections in 2010. The checklist showed the focus areas for inspection, the recommended practice, the wards/units inspected, and the extent of compliance. However, as stated in paragraph 2.8 of the Audit Report, such a checklist was not used for inspections conducted in 2011 and 2012. There were also no records readily available showing details of the private hospital's reports/records that had been inspected, or the procedures/practices examined in each service area or department visited. The Committee asked why the ORHI inspection team had not used the inspection checklist in 2011 and 2012.

12. The **Director of Health** explained and elaborated in her letter of 21 November 2012 (in Appendix 20) that:

- the COP constituted the basis of assessment of the suitability of a private hospital for registration under the Ordinance, and the inspection checklist only served as one of the tools for guiding the inspections. Compliance with the requirements set out in the COP was a condition for the registration and re-registration of private hospitals. As such, the ORHI inspection team considered that they should refer to the COP in conducting inspections since September 2010;

- also, inspection reports were prepared after the inspections for documenting the overall assessment and the DH's advice on areas that needed rectification and improvement; and

- upon Audit's recommendation, the ORHI had revisited the issue and had decided to use an inspection checklist again in the inspections conducted since September 2012.

13. According to paragraph 2.13 of the Audit Report, a scrutiny of the inspection reports of two selected hospitals revealed that some of their service areas had not been inspected by the ORHI inspection team for three years. Upon Audit's enquiry in September 2012, the DH confirmed that those service areas of the two selected hospitals had been covered in the inspections conducted in 2011 because they were covered in the inspection plans of 2011. The Committee was concerned whether, in the absence of appropriate records in the inspection reports, the DH could ensure that all service areas of private hospitals had been covered in its inspection programme.

14. **Dr Amy CHIU**, the **Assistant Director of Health (Health Administration and Planning)**, explained that:

- those service areas of the two selected hospitals referred to in paragraph 2.13 of the Audit Report had been inspected in 2011 but were omitted from the inspection reports due to an oversight; and

- the ORHI inspection team confirmed that they had conducted the inspections in strict accordance with the respective inspection plans, and those service areas were either in the vicinity of or shared the same facilities of other service areas which had been inspected.

15. At the request of the Committee, the **Director of Health** provided a copy of the inspection plans and a copy of the inspection reports of the two selected hospitals referred to in paragraph 2.13 of the Audit Report after the public hearing (in ***Appendices 22 and 23***).

16. The Committee noted from paragraph 2.11 of the Audit Report that the ORHI normally documented the results of an inspection in an inspection report. Nonetheless, Audit found that results of the 32 of the 116 inspections conducted in 2011 for purposes including annual inspections, ad hoc inspections, follow-up inspections, and inspections for matters relating to registration had not been documented in any inspection reports. Of the 32 inspections not covered by any inspection reports, five had their key results documented in file minutes of the relevant subject folders. For the remaining 27 inspections, the DH only provided a variety of documents (extracting from different files and mainly in the form of notes of meetings) showing the work done by the ORHI but not the inspection reports. The Committee considered that there was room for improvement in the ORHI's system of documentation of the various types of inspections conducted on private hospitals. As a good management practice to facilitate monitoring of inspection work and future work planning, the DH needed to ensure that the ORHI properly documented each and every inspection conducted, preferably in the form of an inspection report.

17. The **Director of Health** responded that:

- of the 116 inspections conducted in 2011 for purposes including annual inspections, adhoc inspections, follow-up inspections, and inspections for matters relating to registration, an inspection report was prepared for each of the 40 annual inspections and 31 adhoc inspections, whilst an integrated report was compiled for all the 23 follow-up inspections which were related to an overall review of electricity supply and distribution systems at individual private hospitals;

- for the remaining 22 inspections for matters relating to registration, 13 inspections reports and nine minute sheets respectively were prepared; and

- to facilitate records management, she agreed that the DH should compile an inspection report after each inspection.

18. Noting that some of the existing private hospitals were operating wholly or partly on sites granted by the Government through private treaties at nil or nominal premium and were subject to relevant land grant conditions, the Committee asked whether the DH's inspection programme had covered the private hospitals' compliance with relevant land grant conditions.

19. The **Director of Health** said that in response to Audit's recommendation, a checklist on compliance with land grant conditions had been introduced in September 2012. The relevant checklist is in ***Appendix 24***.

Regulatory actions arising from inspections

20. As revealed in Table 2 in paragraph 2.19 of the Audit Report, the DH only issued eight advisory/warning letters from 2009 to 2011 in respect of various irregularities found during inspections. The Committee asked about the criteria under which an advisory or warning letter would be issued to private hospitals if irregularities were found during inspections.

21. The **Director of Health** replied and stated in her letter of 28 November 2012 (in Appendix 21) that:

- against findings from the 32, 33 and 40 annual inspections conducted from 2009 to 2011, the DH gave 85, 95 and 67 pieces of verbal advice to the private hospitals concerned;

- since 2010, all advice given during the inspections had been subsequently included in the respective written summary of the inspections to individual hospitals and discussed at the meetings with the hospital management;

- in 2011, six regulatory letters were issued to six private hospitals against findings from the 71 annual and adhoc inspections. A total of eight common irregularities were identified; and

- according to the Protocol, the ORHI would, in general, issue an advisory letter to the hospital concerned if one or more of the following irregularities were noted in the inspection:

(a) non-compliance with established policies and procedural guidelines;

(b) lack of guidelines/protocols on essential procedures that link to patient safety; and

(c) inadequacies that require prompt rectification/improvement; and

- a warning letter would be issued if the issues concerned accommodation, staffing or equipment.

22. The Committee noted from paragraph 2.21 of the Audit Report that all regulatory letters were issued by the DH under the same letterhead and there was no caption or subject title to indicate explicitly whether a letter was an advisory or warning letter. The Committee questioned how the DH could ascertain that the hospitals concerned would understand the seriousness of the issues and the consequence of failure to undertake prompt rectification.

23. The **Secretary for Food and Health** accepted Audit's observation that regulatory letters with appropriate caption or subject title would eliminate any chance of miscommunication and facilitate the DH's monitoring of any rectification to be taken by the hospitals concerned.

24. The **Director of Health** said that apart from the issuance of regulatory letters, the DH also followed up with the hospitals concerned and conducted adhoc/follow-up inspections to ensure timely rectification of the irregularities.

25. In response to the Committee's request, the **Director of Health** provided a copy of a regulatory letter (in ***Appendix 25***) after the public hearing.

26. Audit reported in paragraph 2.22(a) to (d) that for some inspections in which serious irregularities were detected, the DH only gave verbal advice or attached a summary report of the inspections to the hospitals concerned for follow-up action without issuing an advisory/warning letter. The Committee questioned whether, in the absence of an advisory/warning letter, the hospitals concerned had failed to take the issues seriously and initiate timely rectification or improvement.

27. The **Director of Health** responded that:

- for the specialty centre referred to in paragraph 2.22(a) of the Audit Report, no advisory/warning letter was issued because the specialty centre had ceased operation immediately upon the ORHI's verbal advice;

- for the three cases referred to in paragraph 2.22(b) to (d) of the Audit Report, the ORHI had given verbal advice during the inspections and the advice had been subsequently included in the summary report of the inspections for follow-up actions by the hospital management; and

- she agreed with Audit's recommendation that irregularities found in the above four cases should warrant the issuance of a regulatory letter.

28. To ensure adequate care for the maternity patients and their newborns, the COP sets out special requirements on accommodation, staffing and equipment for a registered maternity home. A non-maternity ward generally does not meet such special requirements. The Committee referred to Case 1 in paragraph 2.27 of the Audit Report and noted that the hospital concerned had been found to have a regular practice of admitting maternity cases to non-maternity wards. Despite the DH's repeated advice or warnings given in its regulatory letters that admission of maternity cases should be restricted to the registered maternity home, the hospital concerned had taken over nine months to rectify the irregularities found. In view of the potential health risk posed to the maternity patients and their newborns, the Committee queried:

- why the DH had not taken immediate regulatory actions in relation to the admission of maternity cases to non-maternity wards by the hospital concerned; and

- why the DH had not imposed a timeframe for the hospital concerned to rectify the irregularities.

29. The **Director of Health** explained that:

- there were practical difficulties for the patients concerned to secure a maternity booking with other hospitals in a short period of time if the hospital was to cease admission of maternity cases to non-maternity wards promptly;

- the hospital concerned had taken remedial measures in the interim, such as re-deployment of additional midwives to take care of the maternity patients in the non-maternity wards;

- the ORHI had included in the certificate of re-registration issued in December 2011 additional licensing condition, i.e. the hospital should restrict admission of maternity clients to the registered maternity home;

- the hospital concerned had subsequently applied for expansion of its maternity services from 25 to 35 maternity beds and had undertaken to recruit sufficient midwives meeting the specified staffing requirements as soon as possible; and

- after the follow-up inspection conducted in February 2012, the ORHI confirmed that the specified licensing condition had been complied with.

30. The **Secretary for Food and Health** said that:

- the DH was determined to deal with each case of irregularities effectively and step up its regulatory actions if patient safety was at stake;

- under the existing regulatory regime, the Director of Health was empowered to refuse registration or re-registration of a private hospital, if he/she was satisfied that, for reasons connected with accommodation, staffing or equipment, the hospital was not fit to be used for or in connection with a hospital of such description as the hospital named in the application for registration or re-registration, etc.;

- nonetheless, none of the past cases involving irregularities was in serious violation of the specified conditions that warranted refusal of registration or re-registration of any private hospitals; and

- there was a need to review the legislation so as to provide for various types of sanctions or penalties that could reflect the seriousness of the various irregularities, and the potential threat posed to the patient safety as well as public health.

31. The Committee noted from paragraphs 2.20 and 2.26 of the Audit Report that the ORHI had not initiated any prosecution action and only issued six advisory/warning letters to six private hospitals in 2011 in respect of various irregularities found during the inspections. The Committee asked about:

- the manpower situation of the ORHI; and

- whether the DH had any plan to enhance the manpower support of the ORHI.

32. The **Director of Health** replied that:

- the ORHI was headed by a Principal Medical and Health Officer who also headed the Narcotics and Drug Administration Unit. Between 2005 and 2010, the ORHI had six professional staff supporting the Principal Medical and Health Officer. With effect from 2011, there were 11 professional staff in the ORHI; and

- depending on the recommendations of the Steering Committee and the outcome of subsequent public consultation(s), the DH would consider enhancing its staff strength in light of the operational demands arising therefrom.

Closure arrangements

33. Instead of developing guidelines to assist the private hospital in the closure arrangements, the Committee noted from paragraph 2.31 of the Audit Report that the DH instructed the Hong Kong Central Hospital concerned to submit a plan on its closure arrangements. The Committee asked:

- whether the DH found the hospital's plan on its closure arrangements satisfactory; and

- when the DH would issue guidelines on closure arrangements of private hospitals.

34. The **Director of Health** said that:

- as closure of a private hospital was unprecedented in Hong Kong, the DH had not issued any specific guidelines on closure arrangements of private hospitals. For the case in question, the DH received the hospital's plan on its closure arrangements, scrutinized the hospital's weekly submission of service data and conducted inspections at various stages to ensure its compliance with the Ordinance and the COP, particularly on staffing and equipment; and

- the DH gave advice to the hospital as to when to cease admission of in-patients, how to properly handle the patients' records and medical equipment and waste.

C. Monitoring of sentinel events and complaints

Monitoring of sentinel events

35. The Committee noted from paragraph 3.3 of the Audit Report that the DH had set up a voluntary sentinel event reporting system since 1 February 2007 under which the DH promulgated a list of reportable sentinel events and set out the timeframes for private hospitals' reporting of the sentinel events and submission of investigation reports. According to paragraph 3.6 of the Audit Report, given the voluntary nature of the reporting system, there was a risk of under-reporting. In the interest of public health and patient safety, the Committee asked whether the DH had taken appropriate measures to prevent under-reporting of sentinel events.

36. The **Director of Health** replied that the DH issued instructions, guidance and feedback to private hospitals on the reporting of sentinel events from 2007 to 2011. She supplemented in her letter of 6 December 2012 (in ***Appendix 26***) that:

- in 2009, the DH issued to individual hospitals an annual feedback on the sentinel events reported;

- in 2010, a review of selected sentinel events with points to learn from these events was distributed to all private hospitals;

- starting from 2011, the annual review had been revised and renamed as "Patient Safety Digest" in which selected sentinel events as well as complaints were included; and

- the COP also stipulated that private hospitals were required to develop their own procedures on complaint handling and submit complaint digest to the DH regularly.

37. The **Secretary for Food and Health** stated that the DH would launch campaigns of publicity to enhance awareness of hospital staff, patients and the general public in the importance of timely reporting of sentinel events.

38. As revealed in paragraph 3.8(a) of the Audit Report, a few private hospitals had reported more sentinel events than the others. For example, in 2009, the number of sentinel events reported by two hospitals had accounted for 60% of the total 52 sentinel events reported by all private hospitals. The Committee asked what follow-up actions had been taken by the DH.

39. The **Director of Health** explained and stated in her letter of 28 November 2012 (in Appendix 21) that:

- upon receipt of the notification of a sentinel event, the DH would, in line with established guidelines, gather preliminary information from the hospital, and examine the nature and cause of the sentinel event;

- if serious irregularities were found in the management or healthcare services of the hospital, the DH would conduct on-site inspections to ensure timely rectification taken by the hospital;

- in the annual inspections, the DH would also pay particular attention to those service areas of the respective hospitals in which systemic irregularities had been identified in the preceding year;

- according to the DH's analysis, out of these 52 sentinel events reported in 2009, five cases were identified to be related to procedure compliance, 34 related to patient condition, nine related to complications of surgery and the remaining four cases with unknown reason; and

- in 2009, the DH had issued a regulatory letter each to two hospitals for irregularities found.

40. The Committee noted from paragraph 3.9 of the Audit Report that 56% of the sentinel events in private hospitals from 2008 to 2011 were not reported to the DH within 24 hours of their occurrence. The longest time taken for reporting a sentinel event was 259 days (i.e. Case 2 referred to in this paragraph). The Committee asked why no regulatory action was taken by the DH against the hospital concerned.

41. The **Director of Health** explained that:

- as the sentinel event reporting system for private hospitals was only set up on 1 February 2007, frontline staff of the hospital concerned might need a longer time to determine whether Case 2, which occurred in December 2007, was a reportable sentinel event; and

- the DH had examined into Case 2 and identified the root cause of the case as "complications of surgery". As it transpired, "common birth trauma" and "common surgical complications" were excluded from the list of reportable sentinel events for private hospitals with effect from 2010.

42. According to paragraph 3.10 of the Audit Report, from 2008 to 2011, in 60 (61%) of the 98 reported cases of sentinel events, private hospitals did not submit the full investigation reports to the DH within four weeks of the occurrence of the events. In five cases relating to sentinel events that occurred in 2007, the hospitals concerned had not submitted any investigation reports to the DH. There was no evidence that the DH had taken any regulatory actions against the hospitals concerned. The Committee asked why the DH had not taken any regulatory actions against the hospitals concerned.

43. The **Director of Health** responded and elaborated in her letter of 6 December 2012 (in Appendix 26) that the DH had looked into the five cases and found that three of them were related to medical equipment and the remaining two related to complications at birth. The DH was of the view that none of these cases warranted the issuance of a regulatory letter.

44. The Committee was concerned that from 2008 to 2011, the DH had only issued three regulatory letters in respect of the 55 cases of delay in the reporting of sentinel events as stated in paragraph 3.11 of the Audit Report.

45. The **Director of Health** responded and supplemented in her letter of 6 December 2012 (in Appendix 26) that:

- according to the "Protocol for Sentinel Event Reporting System (March 2010)", the DH would issue an advisory letter to the hospital concerned if one or more of the following irregularities were noted in the course of investigation of the sentinel events:

  (a) non-compliance with established policies and procedural guidelines;

  (b) repeated reporting of a similar event within a short period of time;

  (c) lack of guidelines/protocols on essential procedures that linked to patient safety; and

  (d) inadequacies that required prompt rectification/improvements.

- a warning letter would be issued if the issues concerned accommodation, staffing or equipment; and

- delays in the reporting of sentinel events had improved gradually. Since 2011, advisory letters had also been issued to private hospitals for any sentinel events not reported to the DH within 24 hours from its occurrence.

46. The Committee noted that in so far as the exercising of powers of the Director of Health under the Ordinance was concerned, section 6(1) of the Ordinance empowered the Director of Health to make regulation in respect of requirements on patients' records and notification to be given of any death occurring in private hospitals. In that regard, an offence might be created under section 6(2) of the Ordinance for the contravention of any regulation made by the Director of Health under section 6(1). By exercising of the power under section 6(1) of the Ordinance, the Director of Health could have made the notification of death of private hospitals' patients to the DH mandatory. The Committee asked whether the Director of Health had any plan to make regulations pursuant to section 6(1) and (2) of the Ordinance.

47. The **Director of Health** replied in her letter of 6 December 2012 (in Appendix 26) that:

- notwithstanding the fact that no regulation had been made pursuant to section 6(1) and (2) of the Ordinance, the COP was promulgated in 2003

to set out the standards of good practices and quality of healthcare services. These standards included requirements on the management of staff, management of the premises and services, protection of the rights of patients and their right to know, the setting up of a system to deal with complaints as well as management of medical incidents, etc. Compliance with the requirements listed in the COP was required for the registration and re-registration of private hospitals under the Ordinance; and

- subject to the outcome of the ongoing review of the Ordinance, the DH would consider the most appropriate and effective legislative means to regulate private hospitals.

48. In view of the long time taken by private hospitals to report sentinel events or submit investigation reports, the Committee queried why the DH had not made the sentinel event reporting system a mandatory requirement for private hospitals.

49. The **Director of Health** explained that in designing the sentinel event reporting system, reference had been made to the World Health Organization's guidelines which advised that successful sentinel events reporting systems should be non-punitive and confidential, and lead to constructive responses. The critical success factors of a sentinel events reporting system lied in that the individuals or institutions who report the incidents were free from fear of retaliation against themselves or punishment of others as a result of reporting, and the identities of the patient, reporter, and institution were not disclosed to any third party.

50. Audit reported in paragraph 3.15 that in response to the Independent Commission Against Corruption ("ICAC")'s recommendation on referral of cases involving professional misconduct to the Medical Council of Hong Kong ("MCHK") or the Nursing Council of Hong Kong ("NCHK"), the DH considered that it was not in a position to directly refer cases to the MCHK or the NCHK as to do so might impinge on patient privacy. In this connection, the Committee asked:

- whether the DH still maintained its stance of not making referral of cases to the MCHK or relevant professional bodies for actions;

- whether the DH had taken any follow-up actions against cases of sentinel events involving professional misconduct; and

- how the DH had dealt with patient privacy when referring cases to the MCHK or relevant professional bodies for actions.

51. The **Secretary for Food and Health** responded and the **Director of Health** stated in her letter of 6 December 2012 (in Appendix 26) that:

- as a prevailing practice, the DH would refer cases suspected of contravening the law or involving professional misconduct to the relevant authorities or statutory bodies for their consideration;

- in 2011, a case related to a treatment centre in a private hospital licensed under the Human Reproductive Technology Ordinance (Cap. 561) was referred to the Council on Human Reproductive Technology. From 2011 to 2012, two death cases related to private hospitals were referred to the Coroner. Apart from the above cases, the DH had also referred complaints against private hospitals to the Hong Kong Police Force, Office of the Privacy Commissioner for Personal Data and Buildings Department;

- other than sentinel events occurred at private hospitals, from January 2009 to November 2012, four cases handled by the DH involving suspected professional misconduct of a registered medical practitioner, a chiropractor and physiotherapists were referred to the respective statutory professional boards and councils; and

- to address the issue of patient privacy, the DH would seek the consent of the patient concerned before making any referral to the MCHK or NCHK, and explain to the patient concerned that he/she would be expected to appear before the MCHK or NCHK, and give first-hand information at the hearing concerning the case involving professional misconduct. If the patient concerned refused to disclose any information or appear before the MCHK or NCHK, the DH would have to seek legal advice on a case-by-case basis to determine how to take the case forward.

52. The Committee welcomed the Secretary for Food and Health's commitment to refer cases of sentinel events involving professional misconduct to the MCHK or relevant authorities or statutory bodies for consideration. To ascertain whether the private hospitals and healthcare professionals were aware of the stance of the DH on referral of cases involving professional misconduct to the relevant professional bodies,

the Committee asked whether consideration would be given to issuing any circular or memorandum for communicating this change to the healthcare sector.

53. The **Secretary for Food and Health** responded that as there was no change to the established procedure, he did not see a need to issue any circular or information paper for the sole purpose of reiterating to private hospitals an established procedure for the referral of cases involving professional misconduct to the relevant professional bodies. Nonetheless, he would continue to communicate with private hospitals with a view to streamlining the referral mechanism.

54. As revealed in paragraph 3.17 of the Audit Report, from 2007 to 2011, the DH issued only three press releases relating to sentinel events in private hospitals, and uploaded an aggregated figure of sentinel events onto its website on a quarterly basis without disclosing the identities of the private hospitals concerned or details of the sentinel events. It appeared to the Committee that this practice did not foster effective public disclosure of sentinel events. The Committee enquired whether consideration would be given to disclosing the identities of the private hospitals concerned and details of the sentinel events without revealing the identities of the patients if the cases were substantiated after investigation.

55. The **Director of Health** indicated that as reported to the Panel on Health Services of the Legislative Council in May 2010, for sentinel events that had significant public health impact, posed ongoing public health risk and were preventable by immediate action, the DH would make public announcements upon receipt of the notification from private hospitals, whilst for unanticipated death cases of or unanticipated serious morbidity of any of the reportable sentinel events, the individual private hospitals would respond to the media concerning the sentinel events. From 2007 to 2011, the DH had issued three press releases on those sentinel events that fulfilled the specified criteria.

56. The Committee understood from paragraph 3.19 of the Audit Report that private hospitals were required to develop their own policies and mechanisms for handling sentinel events, including whether to disclose the events to the public. To facilitate a consistent approach to the handling of sentinel events amongst private hospitals, the Committee asked whether consideration would be given to setting out a uniform mechanism for all private hospitals to follow and the timetable for implementing such a uniform mechanism.

57. The **Director of Health** explained and stated in her letter of 6 December 2012 (in Appendix 26) that:

- since February 2007, the DH had provided the list of reportable sentinel events for private hospitals; and

- since January 2010, the DH had revised the list of reportable sentinel events for private hospitals taking account of the list of reportable sentinel events for public hospitals.

58. The **Secretary for Food and Health** said that the DH would keep the matter in view and take into consideration the recommendations of the Steering Committee which would come up within a year.

59. With reference to paragraph 3.12 of the Audit Report, the ICAC stated in its assignment study of February 2010 that in enforcing the provisions of the Ordinance, the DH adopted a strategy of "partnership approach" towards private hospitals. To ascertain whether the approach adopted by the DH had led to its inadequate enforcement of the provisions of the Ordinance, the Committee asked:

- what the DH meant by adopting a strategy of "partnership approach" towards private hospitals; and

- whether the strategy of "partnership approach" had led to the DH's inadequate enforcement of the provisions of the Ordinance.

60. The **Director of Health** explained that by adopting a "partnership approach", the DH aimed to work together with private hospitals to enhance the quality of healthcare services and standards of patient safety, and the ultimate aim was to protect the interest of customers/patients of private hospitals. She assured the Committee that the DH would not help the private hospitals to conceal any serious irregularities.

61. The **Secretary for Food and Health** pointed out that the provision of quality healthcare services and assurance of patient safety were the primary concerns of the DH in carrying out its functions. As the regulatory authority, the DH had the responsibility to safeguard patient safety through inspection of private hospitals and monitoring of sentinel events. To address growing public concern over the rights and

safety of patients, the DH should step up its regulatory measures in the monitoring of sentinel events.

62. The Committee also noted from the ICAC's assignment study that the DH had not refused any registration or re-registration of private hospitals, nor had it prosecuted any party under the Ordinance. One of the major shortfalls in the system under study was that the offences and sanctions provided under the Ordinance were grossly inadequate to deter attempts to breach the registration conditions. As such, the Committee asked whether the DH had imposed any sanctions, other than refusal of registration or re-registration, in cases of breach of the registration conditions.

63. The **Director of Health** replied that the DH had not found any breaches by private hospitals relating to registration conditions or sentinel events serious enough to warrant refusal of registration or re-registration, or prosecution action.

64. The **Secretary for Food and Health** agreed with the ICAC study that there was a need to make provisions for various degrees of sanctions to deter breaches of the registration conditions.

65. With reference to paragraph 3.18 of the Audit Report, the criteria for disclosing sentinel events and their details in private hospitals were different from those for public hospitals. The Committee enquired whether the DH had any plan to align the systems and practices for disclosing sentinel events in both private and public hospitals, and if so, the timetable for its implementation.

66. The **Secretary for Food and Health** explained that:

- the HA was responsible for the management of all public hospitals in Hong Kong whilst private hospitals were each managed by their respective Operators and, under the Ordinance, were subject to the regulation by the Director of Health. Given the difference in governance structures, there were bound to be differences in the ways they handled sentinel events;

- the Government aimed to improve and sustain service quality of both private and public hospitals through a system of hospital accreditation. According to the HA's experience, a sentinel events reporting system

would have to undergo processes of implementation, reviews and improvements with enhanced publicity and staff training before it became mature. It was envisaged that private hospitals had to undergo similar processes for their sentinel events reporting systems to become mature; and

- in the interim, the DH would work closely with private hospitals with a view to providing timely and practical feedback for further development of the sentinel events reporting system in private hospitals.

67. The **Director of Health** said that the DH would screen the monthly complaint digests for any potential sentinel events unreported and cases that required further investigation and action.

Handling of complaints against private hospitals

68. As revealed in paragraph 3.30 of the Audit Report, five private hospitals had not always submitted the complaint digests monthly to the DH. The Committee asked whether the DH had taken any follow-up actions against these five hospitals.

69. The **Director of Health** responded that the DH had accepted Audit's recommendations and would remind all private hospitals to follow strictly the established guidelines and submit their complaint digests monthly. In the event of late submission, the DH would issue an advisory letter to the private hospital concerned.

70. Audit reported in paragraph 3.32 that, although the DH noted irregularities in the course of investigation of a number of complaint cases, it did not issue advisory/warning letters to the private hospitals concerned. As evidenced in Case 3 (referred to in the same paragraph), although the irregularities found concerned non-compliance with established procedural guidelines or inadequacies that required prompt rectification, the DH had not issued an advisory/warning letter to the hospital concerned. The Committee queried what follow-up actions had been taken by the DH.

71. The **Director of Health** explained that:

- in the handling of Case 3, the DH had given verbal advice to the hospital concerned after its investigation, and the advice had been subsequently included in the replies to the complainants and relevant records of the DH; and

- the DH would in future also include in the report of the inspections in respect of complaints the advice given to the hospitals concerned if the case was found substantiated after investigation.

D. Price transparency in hospital charges

72. According to the COP, patients have the right to know the fees and charges prior to consultation and any procedures in private hospitals. As revealed in paragraph 4.3 of the Audit Report, the DH checked the hospitals' compliance with the COP requirements and, from 2009 to June 2012, detected no non-compliant case regarding provision of charging information by private hospitals. The Committee however noted Audit's observation in paragraph 4.6 that 351 of the 2 063 complaints received by private hospitals from 2009 to June 2011 were related to charges. The Committee queried:

- whether the DH regarded unexpected price increase, unreasonable charges, and price information (including doctor fees) not communicated in advance to patients as compliant cases in accordance with the COP requirements; and

- whether the occurrence of such complaints had reflected that the COP was lack of detailed requirements on the extent of information to be provided and the means for communication of such information to patients.

73. The **Director of Health** replied and the **Secretary for Food and Health** said that:

- according to the COP, private hospitals were required to make available for reference by patients at the admission office, and wherever appropriate, a fee schedule listing the room charges, service charges for common diagnostic tests and treatment procedures, fees for medical supplies and medicines etc.;

- the DH's investigation unveiled that in most of the complaint cases relating to charges, the doctor fees were only made known to patients after the consultation and sometimes complications happened in the course of the treatment resulted in unexpected fee increase arising from additional diagnostic tests or emergency services;

- for those cases in which emergency procedures had to be performed in the course of the treatment, the DH had reminded private hospitals to make known the charges in advance to the patients;

- private hospitals might not be able to communicate the doctor fees in advance to patients in circumstances where the services were not provided by the hospitals per se but by private medical practitioners with admission privileges;

- as far as elective surgeries were concerned, patients might be given various treatment options in relation to the types of medication, medical service or care, etc.; and

- in any cases, private hospitals should make every endeavour to communicate price information in advance to patients.

74. The Committee noted from Table 8 in paragraph 4.9 of the Audit Report that other than obstetric packages, the number of service packages offered by private hospitals varied significantly, ranging from one to over 80 packages. Also, packages offered by most hospitals often did not include doctor fees, thereby rendering difficulty for patients to make price comparison or informed choices about their healthcare. As mentioned in paragraph 4.13 of the Audit Report, Audit had identified some good practices adopted overseas and by the HA. For instances, in Singapore and the USA, details about the average length of stay, 50^{th} percentile and 90^{th} percentile bill size (including doctors' professional fees) according to different ward classes, the average and median charges for hospital services (except those for physician charges) for the most common procedures were published on the websites for easy access by the public. In view of the above, the Committee enquired whether consideration would be given to requesting private hospitals to adopt these good practices.

75. The **Secretary for Food and Health** explained that:

- as the provision of private hospital services in Hong Kong was governed by free market, the Government should refrain from regulating their price level;

- the Government would however make reference to overseas practices and experience when formulating its strategies for improving the quality and standards of private hospital services and enhancing their price transparency;

- to help patients anticipate their health costs and make informed choices, private hospitals had been encouraged to offer their services for various operations and procedures at packaged charges in recent years; and

- as far as overseas practices were concerned, not all of them were applicable to the local circumstances. For example, in some states of the United States, employers were required by law to offer their employees the Health Maintenance Organization ("HMO") options under which healthcare was rendered by those doctors and other professionals who had agreed by contract to treat patients in accordance with the HMO's guidelines and restrictions. Under such circumstances, healthcare price transparency could be achieved.

76. The Committee noted that the Government had, in April 2012, included in the tender documents for private hospital development at two government sites a set of special requirements requesting new private hospitals to publish comprehensive services price list and that at least 30% of the in-patient bed days taken up each year must be for services provided through standard beds at packaged charges. The Committee asked what measures would be taken by the DH to enhance the price transparency of existing private hospitals.

77. The **Secretary for Food and Health** said that:

- the Government had yet to observe whether the arrangements for the inclusion in the tender documents for private hospital development at two government sites a set of special requirements would be conducive to improving price transparency of private hospital services;

- as more details of the healthcare price information were made available on the websites and readily accessible to the public, it was anticipated that more private medical practitioners would be encouraged to enter into agreement with private hospitals to offer their services at packaged charges; and

- to facilitate price comparison, the DH would encourage private hospitals to adopt standardized format and terminology for their fee schedules.

E. Performance measurement and reporting

78. As revealed in paragraphs 5.3 and 5.5 of the Audit Report, only two performance measures had been reported in the 2012-2013 Controlling Officer's Report which focused mainly on output. The Committee asked whether the DH would adopt other performance measures to measure the efficiency and effectiveness of its regulatory work on private hospitals.

79. The **Director of Health** stated in her letter of 6 December 2012 (in Appendix 26) that the DH would take into account Audit's recommendations and develop appropriate effective performance/outcome indicators in respect of its regulatory work on private hospitals (especially for providing the breakdown of inspections conducted for each type of healthcare institutions) during the review of the Ordinance which would be completed within a year.

F. Conclusions and recommendations

80. The Committee:

Overall comments

- finds it unacceptable and inexcusable that:

  (a) the existing regulatory regime under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) ("the Ordinance"), which was enacted in 1936 with major amendments last made in 1966, fails to meet the rising public expectation for a mechanism that could effectively monitor the performance of private hospitals and ensure the provision of quality medical and

healthcare services in light of the rapid development of private hospitals in recent years;

(b) despite the fact that the Department of Health ("DH") completed a review of legislation (including the Ordinance) regulating private hospitals and other healthcare institutions in December 2000 and considered that there was a need to introduce major changes to the regulation of healthcare institutions in terms of scope and regulatory standards, the review of the Ordinance was subsequently held in abeyance;

(c) the Code of Practice ("COP") issued by the DH, which sets out standards of good practices regarding private hospitals' governance, quality management, patient care, risk management, clinical standards, etc. is in lack of any statutory backing, and non-compliance of which only results in the issuance of an advisory/warning letter without relevant prosecution or penalty; and

(d) as the regulatory authority, the DH had failed to fulfill its duties in monitoring the operation of and services provided by private hospitals, particularly, it had failed to ensure effective enforcement of the Ordinance and private hospitals' compliance with the COP in that:

(i) there was a disparity in the mechanism for handling sentinel events, including whether to disclose the events to the public, between public and private hospitals, attributable to the voluntary nature of the reporting system in private hospitals and the absence of a uniform mechanism for private hospitals to follow;

(ii) the checking of compliance with relevant land grant conditions had not been adequately covered in the annual inspections of private hospitals. As such, the DH could not ascertain whether the public could benefit from the provision of free/low-charge beds in those hospitals operating on Government sites granted by private treaties at nil or nominal premium;

(iii) the DH did not refer cases involving professional misconduct of doctors and nurses to the relevant professional bodies for their consideration; and

(iv) the DH had not taken effective measures to improve price transparency of healthcare services provided by existing private hospitals. As reflected by the arrangement introduced in April 2012 to include a set of special requirements such as the publication of a comprehensive services price list in the tender documents for private hospital development at two sites, the Government could have taken administrative measures to impose similar requirements on the operation of existing hospitals to improve price transparency;

- does not accept the Secretary for Food and Health's explanation as to why the revision of the Ordinance has not been vigorously pursued since 2000;

- acknowledges that in recognition of the inadequacies in the regulation of private hospitals identified in the Director of Audit's Report ("the Audit Report"), the Secretary for Food and Health and the Director of Health were committed to taking steps to introduce improvement measures;

- welcomes that, in October 2012, the Government has set up a steering committee to conduct a review on the regulatory regime for private healthcare facilities, and after the review is completed, the Government would then consult the public on the proposal put forward by the steering committee;

- expects the Food and Health Bureau and DH to take on board the recommendations made by the steering committee in introducing necessary legislative amendments to the Ordinance and to adopt a proactive approach in monitoring private hospitals;

Specific comments

Inspection of private hospitals

Department of Health's inspection programme

- finds it unacceptable and inexcusable that:

(a) despite the requirement in the "Protocol for Inspection of Private Hospitals, Nursing Homes and Maternity Homes under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (March 2010)" that a checklist should be used for guiding

and documenting announced and unannounced inspections of private hospitals, such a checklist was not used in the inspections conducted between September 2010 and August 2012 by the Office for Registration of Healthcare Institutions ("ORHI"). Hence, the extent of checking performed by the ORHI could not be ascertained;

(b) for some inspections conducted by the ORHI, no inspection reports or minutes were prepared to document the results; and

(c) although some of the existing private hospitals are operating wholly or partly on sites granted by the Government through private treaty and are subject to relevant land grant conditions, the DH's inspection programme did not cover the checking of private hospitals' compliance with such conditions adequately;

- acknowledges that since September 2012, the DH:

(a) has used a revised checklist to guide the annual inspections and document the results for the purpose of ensuring comprehensiveness of the inspections; and

(b) has started using a specific checklist for checking private hospitals' compliance with relevant land grant conditions and has already incorporated these procedures into the inspection programme;

- notes that the Director of Health welcomes Audit's recommendations in paragraph 2.15 of the Audit Report and will take steps to introduce improvement measures;

Regulatory actions arising from inspections

- finds it unacceptable and inexcusable that:

(a) the DH did not attach great importance to its regulatory actions, resulting in a decreased deterrent effect on the hospital concerned in that:

(i) the DH did not state explicitly whether a regulatory letter issued to a private hospital in respect of irregularities found during inspections was an advisory or warning letter. The private hospital concerned might not be fully aware of the degree of seriousness of the matter;

(ii) for some inspections in which serious irregularities were noted, the DH only provided summary reports of inspection to the hospitals concerned for follow-up actions, but did not issue any advisory or warning letters to them. An example of such serious irregularities included a specialty centre had started operation before the registration of the premises was approved; and

(iii) the DH's regulatory actions were not always effective to ensure prompt remedial actions by the hospitals concerned. For example, as revealed in paragraph 2.27 of the Audit Report, despite the DH's repeated advice or warnings given in its regulatory letters to the hospital concerned that admission of maternity cases should be restricted to the registered maternity home, the hospital concerned took more than nine months to rectify the situation; and

(b) DH's inspection reports completed in recent years revealed common irregularities in some private hospitals and the DH had not disseminated lessons learnt from these cases to all private hospitals;

- notes that the Director of Health welcomes Audit's recommendations in paragraph 2.29 of the Audit Report and will take steps to introduce improvement measures;

Monitoring of sentinel events and complaints

Monitoring of sentinel events

- expresses grave dismay and finds it inexcusable that:

(a) given the voluntary nature of the sentinel event reporting system, there is a high risk of under-reporting of sentinel events by private hospitals. A few private hospitals had reported more sentinel events than the others. For example, in 2009, the number of sentinel events reported by two hospitals had accounted for 60% of the total 52 sentinel events reported in the year by all private hospitals;

(b) no regulation had ever been made by the Director of Health under section 6(1) of the Ordinance. Section 6(1) of the Ordinance empowers the Director of Health to make regulation in respect of

requirements on notification to be given of any death occurring in private hospitals. By virtue of section 6(1) of the Ordinance, the Director of Health could have made the notification of sentinel events involving death of patients by private hospitals to the DH mandatory. However, the Director of Health had failed to exercise such power;

(c) the DH had not accorded sufficient attention to the monitoring of the sentinel events reporting system, which aims at identifying areas for improvement in the quality and safety of healthcare services in that:

(i) from 2008 to 2011, 56% of the sentinel events in private hospitals were not reported to the DH within 24 hours of their occurrence, contrary to the requirement under the sentinel event reporting system. In 61% of the reported cases of sentinel events, private hospitals did not submit the full investigation reports to the DH within 4 weeks of the occurrence of the events, contrary to the requirement; and

(ii) for five sentinel events that occurred in 2007, the hospitals concerned had not submitted any investigation reports to the DH, and the DH had not taken adequate follow-up actions;

(d) instead of taking up the role of a regulator, the DH adopted a "partnership approach" towards private hospitals in enforcing the Ordinance. After investigating sentinel events, the DH only issued advisory or warning letters to the private hospitals concerned if the cases were substantiated, and such letters were few. The DH did not refer cases involving professional misconduct of doctors and nurses to the relevant professional bodies for their consideration;

(e) from 2007 to 2011, the DH issued only three press releases relating to sentinel events in private hospitals and uploaded an aggregated figure of sentinel events onto its website on a quarterly basis without disclosing identities of the private hospitals concerned and details of the sentinel events. Hence, the public were not adequately alerted to such sentinel events;

(f) the criteria adopted by the DH for disclosing sentinel events to the public are different from those adopted by the Hospital Authority for public hospitals, and there is no justification for the disparity; and

(g) instead of developing a uniform mechanism for private hospitals to follow, the DH requires the hospitals to develop their own policies and mechanisms for the management of sentinel events;

- notes that:

(a) the Director of Health has accepted Audit's recommendations in paragraph 3.21 of the Audit Report; and

(b) the Secretary for Food and Health has accepted Audit's recommendation in paragraph 3.22 of the Audit Report;

- acknowledges:

(a) the explanation given by the Director of Health that by adopting a "partnership approach", the DH aims to work together with private hospitals to enhance the quality of healthcare services and standards of patient safety, and the ultimate aim is to protect the interest of customers/patients of private hospitals. The Director of Health reassured the Committee that the DH will not help the private hospitals to conceal any serious irregularities;

(b) the Secretary for Food and Health's stance that the DH will play the role of a regulator as well as that of a partner in the regulation of private hospitals; and

(c) that, for cases of sentinel events involving professional misconduct or substandard performance of significant public health impact, the DH would refer the cases to relevant professional bodies for action;

Handling of complaints against private hospitals

- expresses grave dismay and finds it inexcusable that:

(a) notwithstanding the fact that the complaint digests are useful for the DH to screen for any potential sentinel events unreported, five private hospitals had not always submitted the complaint digests monthly to the DH as required by the COP; and

(b) although the DH noted irregularities in the course of its investigation of a number of complaint cases, it did not issue advisory or warning letters to the private hospitals concerned. Such irregularities

included non-compliance with established procedures or inadequacies that required prompt rectification;

- notes that the Director of Health has accepted Audit's recommendations in paragraph 3.38 of the Audit Report;

Price transparency in hospital charges

- expresses dissatisfaction and finds it unacceptable that:

  (a) despite the COP provides that patients have the right to know the fees and charges prior to consultation and any procedures, a large number of complaints received by private hospitals and the ORHI were about unexpected price increase, unreasonable charges and price information (including doctor fees) not communicated in advance to patients;

  (b) contrary to the practice of the Hospital Authority to make available comprehensive price information on its private services on the website, most private hospitals did not provide comprehensive price information for their services except those offered at packaged charges, and the availability of charging information to the public varied considerably among private hospitals. It was difficult for customers to make price comparison or informed choices about their healthcare; and

  (c) the DH had failed to take adequate measures to address the problem of the lack of price transparency in private hospitals;

- notes that:

  (a) the Government had, in April 2012, included in the tender documents for developing new private hospitals at two sites a set of special requirements such as the need for the new hospitals to publish a comprehensive services price list and to provide services at packaged charges;

  (b) the Director of Health has agreed with Audit's recommendations in paragraph 4.16 of the Audit Report; and

  (c) the Secretary for Food and Health has agreed with Audit's recommendation in paragraph 4.17 of the Audit Report;

- urges the Secretary for Food and Health, in collaboration with the Director of Health:

  (a) to continue to encourage private hospitals to offer more services at packaged charges, thereby enhancing price transparency; and

  (b) to formulate guidelines for private hospitals to adopt standardised format and terminology for their fee schedules for the purpose of facilitating price comparison;

Performance measurement and reporting

- expresses serious concern that:

  (a) the two performance measures reported by the DH in the 2012-2013 Controlling Officer's Report ("COR") focus mainly on output and are inadequate for measuring the efficiency and effectiveness of the DH's regulatory work on private hospitals; and

  (b) regarding the performance measure on the number of inspections of licensed institutions reported in the 2012-2013 COR, there was no breakdown of the number and type of inspections carried out for each type of healthcare institution (e.g. private hospital and nursing home);

- notes that:

  (a) the Food and Health Bureau and the DH have commenced a review of the Ordinance, and the DH will take into account the audit recommendations about developing appropriate effective performance/outcome indicators when conducting the review; and

  (b) the Director of Health has accepted Audit's recommendations in paragraph 5.7 of the Audit Report;

Way forward

- expresses concern that there is insufficient manpower in the ORHI for inspecting private hospitals and monitoring sentinel events;

- notes that:

  (a) to ensure that the services of the new hospitals are of good quality and will cater for the needs of the general public, a set of special requirements for private hospital development, covering aspects such as land use, service scope, packaged charge and price transparency, and service standard had recently been included by the Government in the tender documents for developing private hospitals at two sites, and a number of measures could be taken by the Government if the successful tenderer breaches any of its obligations;

  (b) in October 2012, the Government set up a steering committee to conduct a review on the regulatory regime for private healthcare facilities. On 18 December 2012, the Government announced that the Working Group on Regulation of Private Hospitals ("the Working Group") under the auspices of the Steering Committee on Review of the Regulation of Private Healthcare Facilities has been formally set up and come into operation. The Working Group is tasked with reviewing the scope of the existing legislation and the regulatory regime for private hospitals, and formulating recommendations for enhanced control of different aspects related to the provision of healthcare services by private hospitals. It will gather views of stakeholders concerned and make reference to overseas regulatory frameworks that are applicable to local circumstances when undertaking its duties. The Working Group would submit its findings to the Steering Committee in the second half of 2013, with recommendations on the regulatory framework that should be adopted for private hospitals;

  (c) prior to the amendments of the regulatory regime, the DH will take measures with reference to the audit recommendations to enhance and strengthen the supervision and regulation of private hospitals; and

  (d) the Secretary for Food and Health and the Director of Health have agreed with the audit recommendations in paragraph 6.14 of the Audit Report;

- urges the Director of Health to report to the Panel on Health Services ("HS Panel") of the Legislative Council on the progress of the implementation of the special requirements for the new hospitals;

- urges the Secretary for Food and Health to report to the HS Panel on the recommendations of the Working Group, and the progress of the review of the Ordinance; and

Follow-up action

- wishes to be kept informed of the progress made in implementing the various recommendations made by the Committee and Audit.