立法會
Legislative Council

LC Paper No. CB(2)2873/02-03
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of special meeting
held on Wednesday, 21 May 2003 at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon LO Wing-lok (Chairman) Hon Michael MAK Kwok-fung (Deputy Chairman) Hon Cyd HO Sau-lan Hon CHAN Kwok-keung Hon Andrew CHENG Kar-foo Dr Hon LAW Chi-kwong, JP Hon LI Fung-ying, JP
Members absent	:	Hon Albert HO Chun-yan Hon CHAN Yuen-han, JP Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP Dr Hon YEUNG Sum Dr Hon TANG Siu-tong, JP
Members attending	:	Dr Hon David CHU Yu-lin, JP Hon Fred LI Wah-ming, JP Hon LEUNG Yiu-chung Hon TAM Yiu-chung, GBS, JP Hon Albert CHAN Wai-yip Hon IP Kwok-him, JP
Public Officers attending	:	Mr Thomas YIU, JP Deputy Secretary for Health, Welfare and Food (Health)

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Miss Eleanor JIM
Assistant Secretary for Health, Welfare and Food (Health) 7

Dr P Y LEUNG, JP
Deputy Director of Health (1)

Dr P Y LAM, JP
Deputy Director of Health (2)

Dr Thomas TSANG
Consultant (Community Medicine)
Department of Health

Dr W M KO, JP
Director (Professional Services & Public Affairs)
Hospital Authority

Dr Loretta YAM
Chief of Service, Department of Medicine
Pamela Youde Nethersole Eastern Hospital

Clerk in attendance : Ms Doris CHAN
Chief Assistant Secretary (2) 4

Staff in attendance : Miss Mary SO
Senior Assistant Secretary (2) 8

Special meetings in June 2003

The Chairman sought members' view as to whether the weekly special meetings should continue to be held in June 2003. Members agreed to continue the weekly meetings. As the first Wednesday in June (4 June) was a public holiday, members agreed to defer the meeting to the following day on 5 June at 8:30 am.

2. The Chairman said that he had received a letter from Mr WONG Sing-chi requesting the Panel to follow up the incident of mixing up the identity of two

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elderly patients at the North District Hospital. Members agreed to follow up the matter. In response to the Chairman, Deputy Secretary for Health, Welfare and Food (DSHWF) said that an investigation was being conducted to find out why the mix-up had occurred. The Administration should be in a position to discuss the matter at the next special meeting scheduled for 28 May 2003.

I. Update on the Severe Acute Respiratory Syndrome

(LC Paper Nos. CB(2)2143/02-03(01) and (02))

3. DSHWF updated members on the latest development in Severe Acute Respiratory Syndrome (SARS) as set out in the Administration's paper (LC Paper No. CB(2)2143/02-03(02)).

Infection control

4. Mr LEUNG Yiu-chung said that many health care workers considered working in high risk areas, such as SARS wards and intensive care units (ICUs), safer than working in low risk areas of the hospitals because of the higher level of protective gear and apparel provided. In view of the continued occurrences of hospital staff working in low risk areas infected with SARS, Mr LEUNG asked whether the Hospital Authority (HA) would improve the protective gear and apparel for these staff. Mr LEUNG further asked whether HA would provide training on infection control to supporting hospital staff, such as the health care assistants (HCAs), who were not professional health care workers.

5. Director (Professional Services & Public Affairs), Hospital Authority (Director, HA) responded that arrangements were underway to improve the protective gear and apparel for hospital staff working in non-high risk areas. For instance, hospital staff working in non-high risk areas would all be provided with surgical masks and goggles. Other items, such as face shields, disposable gloves and gowns, would also be provided freely to staff upon request. As regards provision of training for non-professional hospital staff in infectious disease control, Director, HA agreed that this was necessary and needed to be enhanced. In addition to the one-day training session in infectious disease control for non-professional hospital staff organised by each hospital, further training on the same would be conducted by HA Head Office in each hospital cluster. Director, HA further said that a resource centre, manned by staff trained in infectious disease control, would gradually be set up in the hospital clusters to advise staff on the usage of different types of protective gear and apparel and how to wear them properly.

6. Mr Michael MAK pointed out that since the outbreak of SARS, there had been incessant cases of health care workers of public hospitals making telephone

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calls to radio programmes to complain about the shortage of protective gear HA had provided to them. In this connection, Mr MAK asked whether the problem was due to the middle management in hospitals deliberately holding up the supply of protective gear for frontline staff because of insufficient stock.

7. In reply, Director, HA said that he did not believe that middle management in hospitals had deliberately held up the supply of protective gear for frontline staff. To strengthen its supplies management in the fight against SARS, HA had set up a Working Group on Supplies and Environmental Control. The Working Group had reviewed the problems relating to the supply of protective gear for frontline staff. The Working Group had identified, amongst others, that there was room for improvement in the communication between the middle management in a few hospitals and both frontline staff at the ward level, and the Supplies Office in HA Head Office. To rectify the problem, the Hospital Chief Executives of these hospitals had already put in place mechanisms to ensure effective communication amongst the parties concerned. The middle management of these hospitals would proactively communicate with frontline staff regarding their concern about the supply of necessary protective gear to ensure work safety, and report unresolved issues/problems to the attention of the senior management. The hospitals concerned had been advised to communicate closely with the Supplies Office in HA Head Office on their requirements for protective gears. The Working Group would monitor the effectiveness of the new mechanisms on a regular basis and suggest further improvements where necessary. Director, HA further said that HA had also set up a 24-hour SARS hotline to enhance communication with frontline staff. Feedback and suggestions from staff would be referred to relevant clusters and hospitals for immediate follow-up action.

8. Mr Andrew CHENG said that the guidelines issued by the New Territories East (NTE) cluster on infection control stipulating, amongst others, that only staff working at high risk areas would be provided with N95 masks, was unreasonable. This was evidenced by the fact that many health care staff working in low risk areas, such as the general wards, had contracted SARS. Given the claim made by HA that it had ample stock of protective gear, there was no reason for HA not to provide staff with N95 masks to work at low risk areas.

9. Director, HA clarified that the guidelines issued by NTE cluster on infection control were recommendations and not rules. The reasons why NTE cluster would not automatically provide staff working in non-high risk areas with N95 masks but surgical masks were twofold. Firstly, it was due to the short supply of small-sized N95 masks. Secondly, surgical masks had been scientifically proven to be effective in preventing users from contracting SARS as the disease was mainly transmitted by respiratory droplets. Despite the aforesaid, staff working in non-high risk areas would not be denied the use of N95 masks if

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they so wished. Moreover, staff working in general wards would be required to wear N95 masks if they were exposed to high risk of infection, such as performing orotracheal intubation on patients. Director, HA further clarified that there was no such thing as low risk areas in public hospitals. All areas in public hospitals were either classified as high risk or other areas, and high risk areas generally referred to SARS wards, ICUs and emergency and accident departments.

10. Having regard to the comments made by Director, HA that staff working in non-high risk areas would not be denied the use of N95 masks if they so wished, Mr CHENG requested HA to make this clear in the guidelines on supply of protective gear so as to help workers felt assured of being sufficiently protected.

11. Director, HA reiterated that HA had never denied staff the use of N95 masks. The reasons why priority of the use of N95 masks was accorded to staff working in high risk areas were because surgical masks had been proven to be effective in preventing SARS and there would be a shortage of N95 masks if all frontline health care staff had to wear them. Director, HA further said that HA did not set any limit on the procurement of N95 masks, and would buy as many N95 masks as were available in the market. DSHWF supplemented that in view of the great demand for the small-sized N95 masks in places outside Hong Kong, HA was only given a certain quota of the production by manufacturers. The United States Consulate in Hong Kong had been requested to provide any possible assistance in this matter. DSHWF further said that during his visit to the Tai Po Hospital and the Alice Ho Miu Ling Nethersole Hospital last week, he had observed that protective gear for frontline workers working in high risk areas and non-high risk areas was practically the same as a result of the strengthening of hospital infection control mechanism at all workplaces.

12. Dr David CHU said that it was unacceptable that infections of health care workers had continued to rise. Dr CHU further said that N95 masks were not the only high protection level masks on the market, and consideration should be given to procuring N99 and N100 masks. Director, HA responded that this had been done. Director, HA reiterated that HA would not spare any expenses in procuring any item of protective gear, so long as they met the international standards.

13. Ms Cyd HO asked whether HA had organised any experience sharing sessions to enable staff from other public hospitals to learn infection control from Queen Mary Hospital (QMH) which had so far succeeded in zero infection amongst its health care workers.

14. Director, HA responded that HA had a mechanism for adequate experience sharing amongst its staff, and experience sharing sessions on infection control by experts from QMH had been held. Moreover, experts from QMH also served on

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an expert group under HA's Central Committee on Infection Control on SARS to handle and decide on professional and technical issues. Director, HA, however, pointed out that although the general principles of infection control adopted by each hospital were basically the same, there were variations in how each hospital implemented infection control. For instance, some experts considered it necessary to wear gloves in caring for SARS patients, while others considered it more important to wash hands thoroughly after caring for SARS patients.

Compensation for HA staff who contracted SARS while on duty

15. Mr LEUNG Yiu-chung expressed concern that non-permanent HA employees, such as HCAs, had to pay their medical expenses out of their own pockets. In the light of this, Mr LEUNG asked whether non-permanent HA employees would be compensated for contracting SARS while on duty.

16. Director, HA responded that HA had recently extended medical benefits to its non-permanent employees. Moreover, non-permanent HA staff would be compensated for contracting SARS while on duty in accordance with the Employees' Compensation Ordinance. Director, HA further said that HA was presently studying the feasibility of arranging additional insurance coverage for its staff. Director, HA, however, pointed out that there was a possibility that insurance companies might not be interested in offering such insurance policy on the ground that not very much was known about the pathogen which caused SARS. If that was the case, alternatives would be sought. At the request of the Chairman, Director, HA, undertook to provide information on the compensation for HA staff at all levels who contracted SARS while on duty for discussion at a future meeting.

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17. Ms LI Fung-ying pointed out that due to inadequate provision of protective gear to health care workers, some of them had resorted to bringing their own protective gear to work. In the light of this, Ms LI asked whether HA would compensate these staff who contracted SARS in the course of their duties. Director, HA replied in the positive.

18. Mr TAM Yiu-chung said that the compensation for HA employees who unfortunately contracted SARS and died in the course of taking care of SARS patients in HA hospitals under the Employees' Compensation Ordinance was far from adequate, especially for doctors, and should be improved. Director, HA responded that HA was presently looking at ways of improving the compensation for its staff who sacrificed their lives in the course of taking care of SARS patients.

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Preventive measures in respect of frail elders in residential care homes for the elderly (RCHEs)

19. Mr Andrew CHENG said that the Prince of Wales Hospital (PWH) had recently refused to admit a patient from a RCHE with high fever on the ground that it did not have a hospital bed to accommodate the individual concerned. Instead, PWH had instructed the operator of the RCHE to isolate the elderly patient from other residents. This was unreasonable, as the RCHE concerned did not have the isolation facility nor the necessary protective gear for its staff. Moreover, RCHE staff were not trained in infection control.

20. Director, HA believed that the reason why PWH refused to admit an elderly patient with high fever was because the patient concerned was not determined by doctors to be a probable SARS case. Hence, it was in the best interests of the patient to confine himself/herself at the RCHE to avoid getting infected at the hospital. Director, HA further said that as many elders in RCHEs were frequent users of hospital services and were a high risk group for SARS, HA had enhanced coverage of its Community Geriatric Assessment Teams to RCHEs to obviate the need of these elders to seek medical treatment at the hospitals as far as possible in this critical period. Moreover, HA had enlisted the assistance of the Social Welfare Department and voluntary groups to render support to RCHEs on the prevention of SARS. DSHWF supplemented that in addition to stepping up visits to RCHEs by HA's Community Geriatric Assessment Teams, the medical needs of some RCHEs were being met by private doctors participating in the Visiting Medical Officers (VMOs) Scheme.

21. Responding to Dr LAW Chi-kwong and Mr TAM Yiu-chung's enquiry on the progress made in enlisting Visiting Medical Officers to meet the medical needs of RCHEs, DSHWF said that about $16 million from the $200 million commitment created on 31 March 2003 for work relating to combating SARS would be used to fund the recruitment of VMOs.

22. Mr TAM Yiu-chung asked whether consideration would be given to setting up a centre to accommodate elderly from RCHEs who needed to be isolated, having regard to the fact that the great majority of RCHEs did not have the space nor the facility to do so.

23. Director, HA responded that in view of the fact that elderly in RCHEs were a high risk group for SARS, an elderly in RCHE diagnosed to be a suspected case would be kept under close observation in hospital. After treatment, he/she would be sent to the Wong Tai Sin Hospital to undergo convalescence before discharge.

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Lifting of travel advisory against Hong Kong by the World Health Organization (WHO)

24. Noting that one of the criteria laid down by WHO for lifting the travel advisory against Hong Kong was that the number of SARS patients receiving treatment in hospitals must fall below 60, Mr IP Kwok-him asked when Hong Kong would meet such criterion.

25. Director, HA responded that it was very difficult to say when Hong Kong could meet the requirement of having less than 60 SARS patients receiving treatment in hospitals, as this would depend on factors such as the clinical conditions of patients, the number of new cases and the number of patients receiving treatment in ICUs. Director, HA pointed out that although the normal treatment period for a SARS patient was 21 days, a much longer treatment time would be needed for a SARS patient receiving treatment in ICU. At the request of Mr IP, Director, HA undertook to provide more detailed classification of SARS patients in ICUs of HA.

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26. Mr Fred LI hoped that the Administration would refrain from giving a false hope to the public that SARS was coming under control and that WHO would soon lift its travel advisory against Hong Kong. Mr LI was of the view that the Administration should provide more information on the number of patients receiving treatment in ICUs and their duration thereat. In response, DSHWF said that there was no question of such a situation, as the Administration had been very transparent in laying out to the public the criteria set by WHO for lifting the travel advisory against Hong Kong. DSHWF further said that the information requested by Mr LI was made to the public at DH's daily press briefing and on its daily SARS bulletin. Nevertheless, he undertook to see what more could be done to improve the comprehensiveness of the information in this regard.

Distribution of workload amongst public hospitals in treating SARS patients

27. Ms Cyd HO asked about the measures which would be taken by HA to rectify the present uneven distribution of workload amongst public hospitals in treating SARS patients.

28. Director, HA said that there was no question of unfair distribution of workload amongst public hospitals in treating SARS patients. Director, HA pointed out that there were divergent views amongst experts on the advantages of treating SARS patients under one roof in one hospital or spreading them out in several hospitals. In his view, the first approach was more preferable during the early stage of the outbreak of the disease when the number of confirmed SARS patients was small. However, the second approach was necessary when the number of SARS cases increased to such an extent that no single hospital in Hong

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Kong could cope with a large number of cases. However, in order to avoid the risk of cross infection while transporting large number of SARS patients from one hospital to another, there was a need to confine the number of hospitals designated for treating SARS patients to a reasonably small number. Hence, Princess Margaret Hospital (PMH) was designated as the primary receiving hospital for new SARS cases during the early outbreak of the disease because it had a designated infectious disease centre equipped with dedicated facilities for handling patients with infectious diseases. The upsurge in the number of SARS cases brought about by the outbreak at Amoy Gardens had, however, necessitated HA to divert patients to other acute hospitals. Director, HA explained that the reason why United Christian Hospital (UCH) and PWH were also receiving many SARS cases was because they were located in the districts in which the major outbreaks had occurred. To alleviate the workload on UCH and PWH, arrangements had been made to transfer some of their SARS patients to public hospitals on the Hong Kong Island.

29. Ms HO further said that, apart from developing a system of warden in hospitals to see that staff strictly observed infection control measures, consideration should be given to deploying staff from QMH experienced in infection control to work in other public hospitals. Ms HO also raised concern about whether the hospital cluster arrangement was working effectively in dealing with the outbreak, and whether it had created difficulties in staff deployment between the hospital clusters to deal with sudden upsurge in workload in some hospitals. Although it was understandable that caring of SARS patients should be confined to a few hospitals, Ms HO considered that this should not prevent HA from deploying health care workers from other public hospitals to work at UCH and PWH to alleviate the workload of UCH and PWH staff.

30. Director, HA disagreed that the hospital cluster arrangement was not working effectively in dealing with the outbreak. For instance, immediately following the outbreak of SARS at Amoy Gardens, doctors and nurses trained in ICU work from all hospitals under HA had been deployed to help out at PMH. Another example was that when the ICU facilities at UCH had reached its full capacity, arrangements had been made to transfer patients who had a high chance of requiring ICU treatment to ICUs in hospitals in other clusters.

Figures of other cases in public hospitals which had accumulated following the SARS outbreak

31. Ms Cyd HO asked about the figures of other cases in public hospitals which had been accumulated following the SARS outbreak. Director, HA undertook to provide the figures of other cases in public hospitals which had accumulated following the SARS outbreak before the next meeting. Director, HA further said that most of the hospitals had gradually resumed their specialist

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out-patient and surgical services in the light of SARS coming under control.

Criteria of affected building and health checks at border control points

32. Mr Michael MAK hoped that the press release issued by the Department of Health (DH) on the number of SARS cases could be made more comprehensive. Mr MAK then asked the following questions -

(a) What were the criteria adopted by DH for designating a building as an affected building, having regard to the fact that DH had failed to disclose the name of the hotel which had received a hotel guest who later was confirmed with SARS; and

(b) Whether the two persons confirmed to have SARS since the implementation of health checks at border control points, referred to in paragraph 13 of LC Paper No. CB(2)2143/02-03(02), were Mainlanders.

33. DDH(2) undertook to examine how the press release issued by DH on the number of SARS cases could be made more comprehensive. As regards Mr MAK's first question, DDH(2) said that a building would be designated as an affected building for a maximum period of 10 days once it was found that it had a resident who was a confirmed or suspected SARS patient. As affected buildings hitherto were residential buildings, DH would need to consider whether, and if so, what sort of criteria should be adopted for designating a hotel as an affected hotel. As to Mr MAK's second question, DDH(2) said that the two persons referred to in paragraph 13 of the paper were Hong Kong residents. DDH(2) further said that to his understanding, these two persons were identified as SARS patients prior to implementation of temperature screening.

Ventilation of hospital wards

34. Mr Fred LI urged HA to expeditiously improve the ventilation of hospital wards to reduce infection amongst health care workers and patients.

35. Director, HA responded that ideally, SARS patient should be isolated in a room having negative pressure relative to surrounding accommodation. The negative pressure was created by extracting more air than the air-conditioning supply to the room. The surrounding air would therefore flow into the room, or in other words, preventing the room air from leaking into surrounding accommodation. Director, HA, however, pointed out that not all public hospitals had negative pressure facilities because not all of them were built to receive infectious disease cases and the fact that patients suffering from other ailments needed positive pressure facilities instead. Nevertheless, in the light of SARS

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outbreak, every effort had been made to improve the ventilation of SARS wards by installing exhaust fans to extract more air from these wards so as to bring about the required negative pressure effect. However, the installation of additional exhaust fans in the existing wards setting would end up in pumping out a lot of the cool air-conditioned air and the wards would become hotter. HA was now working with the Electrical and Mechanical Services Department to identify means to improve the comfort level of these areas.

36. Chief of Service, Department of Medicine, Pamela Youde Nethersole Eastern Hospital (Chief of Service, PYNEH) supplemented that given the varied needs of patients, a delicate balance had to be struck in providing negative and positive pressure facilities in hospitals. She pointed out that even in the SARS wards with negative pressure facilities, it was necessary to ensure that other areas within these wards, such as the nurse station, treatment rooms and storage place for medical equipment, had clean air.

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37. At the request of the Chairman, Director, HA undertook to provide information on the number of wards with negative pressure facilities in HA hospitals.

Investigation into the outbreak of SARS at Amoy Gardens by WHO team

38. Dr LAW Chi-kwong asked whether the SARS virus was found in the rats and insects at Amoy Gardens by the WHO investigation team. DDH(1) replied in the negative, as the investigation team was unable to obtain samples of rats and insects at Amoy Gardens. DDH(1) surmised that this might be due to the strong disinfectant used in cleaning up the estate.

Closure of nursery schools and kindergartens

39. Dr LAW Chi-kwong asked whether there were any measures to help parents take care of their children if a nursery school or a kindergarten had to be shut down temporarily because one child had come down with SARS. Dr LAW hoped that such measures were already in place to avoid creating additional burden on parents.

40. DSHWF responded that he was not in a position to answer Dr LAW's question. Nevertheless, he believed that such measures were in place, and that he would convey Dr LAW's concerns to the relevant government department.

Classification of SARS cases

41. Dr LAW Chi-kwong wondered whether the number of atypical pneumonia cases, excluding SARS, in the past two months had dropped in comparison with

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the same figure during the same period last year, and if so, whether this was due to people wearing face masks in the recent months.

42. Director, HA responded that he did not have the information on the number of atypical pneumonia cases, excluding SARS, in the past two months. If there was a drop in the number of atypical pneumonia cases, excluding SARS, in the past two months compared with the same figure during the same period last year, it was possible that this was due to people wearing face masks in the recent months.

43. At the request of the Chairman, Chief of Service, PYNEH briefed members on the criteria used for defining probable and suspected SARS cases. She said that a case would be classified as a probable SARS case if the patient concerned had the following conditions -

(a) Radiographic evidence of infiltrates consistent with pneumonia, and

(b) Fever >38°C or history of such at any time in the past two days, and

(c) At least two of the following -

(i) History of chills in the past two days;

(ii) Cough (new or increased cough) or breathing difficulty;

(iii) General malaise or myalgia; and

(iv) Known history of exposure.

Cases which did not completely fulfil the aforesaid definition but still considered to be highly likely of SARS on clinical judgment would be classified as suspected cases.

44. Chief of Service, PYNEH further said that several ways were presently used to diagnose SARS, notably, molecular tests, antibody tests and cell culture. Chief of Service, PYNEH pointed out that the molecular tests were not very sensitive and the antibody tests were accurate but took too long to become useful for diagnosis. Although cell culture was the most specific diagnostic test for SARS, it was very difficult to culture the virus. Diagnosis of SARS in the early stages of the disease must therefore still be based on clinical findings.

45. Director, HA supplemented that in view of the lack of full understanding of SARS, SARS diagnosis remained to be based on the clinical and epidemiological findings, and that laboratory test result criteria for confirming or

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rejecting the diagnosis of SARS remained to be defined. In the light of this, some cases classified as SARS cases might not be truly SARS cases as doctors could not afford to spend a long time to find out whether the patients concerned had contracted the SARS virus before giving treatment. DDH(1) pointed out that according to WHO, SARS cases were classified as either suspected or probable. Whether such cases should be classified as confirmed had to be determined by serological test for antibodies at a later stage.

46. Dr LAW pointed out that over 90% of the about 3 000 deaths each year from pneumonia were the elderly, which was unacceptable. Dr LAW hoped that the Administration and HA would give regard to this phenomenon in its future review of the whole process of handling the SARS outbreak.

Minimum leave/rest day for health care workers

47. Ms LI Fung-ying said that adequate rest was important in the prevention of SARS. In the light of this, Ms LI asked whether all public hospitals could grant a special leave of one day in every two weeks to staff working with SARS cases now that the number of SARS cases was declining. Ms LI further said that one way to avoid overloading staff working in SARS cases was to rotate their job duties with staff not working with SARS cases.

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48. Director, HA undertook to provide information on the granting of rest days for staff working with SARS cases after the meeting.

49. There being no other business, the meeting ended at 10:47 am.

Council Business Division 2
Legislative Council Secretariat
21 July 2003