立法會
Legislative Council

LC Paper No. CB(2)1605/03-04
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 5 January 2004 at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Hon Michael MAK Kwok-fung (Chairman) Dr Hon LO Wing-lok, JP (Deputy Chairman) Hon CHAN Kwok-keung, JP Hon CHAN Yuen-han, JP Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP Hon Jasper TSANG Yok-sing, GBS, JP Hon Andrew CHENG Kar-foo Dr Hon LAW Chi-kwong, JP Dr Hon TANG Siu-tong, JP Hon LI Fung-ying, JP
Members absent	:	Dr Hon David CHU Yu-lin, JP Hon Cyd HO Sau-lan Dr Hon YEUNG Sum
Member attending	:	Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP
Public Officers attending	:	Items II and III Mr Thomas YIU, JP Deputy Secretary for Health, Welfare and Food (Health)

Action

Mr Tony CHAN
Assistant Secretary for Health, Welfare and Food (Health)

Item II

Mrs Carrie YAU, JP
Permanent Secretary for Health, Welfare and Food

Mr Edward LAW
Principal Assistant Secretary for Health, Welfare and Food (Health)

Dr P Y LAM, JP
Director of Health

Dr Regina CHING
Acting Deputy Director of Health

Item III

Mrs Ingrid YEUNG
Principal Assistant Secretary for Health, Welfare and Food (Health)

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

Item IV

Mr Michael Scott
Senior Assistant Solicitor General

Ms Stella CHAN
Government Counsel

Clerk in attendance : Miss Mary SO
Chief Council Secretary (2) 4

Action

Staff in attendance	:	Ms Amy LEE Senior Council Secretary (2) 8

I. Items for discussion at the next meeting
(LC Paper Nos. CB(2)846/03-04(01) and (02))

Members agreed to discuss the following items at the next regular meeting scheduled for 9 February 2004 -

(a) Results of the consultation exercise on the regulation of medical devices and the way forward;

(b) Cervical cancer screening services; and

(c) Monitoring and enforcement of the sale of pharmaceutical products in Hong Kong.

II. Centre for Health Protection - proposed organisational structure and implementation milestones
(LC Paper No. CB(2)846/03-04(03))

2. Director of Health (D of H) gave a power point presentation on the proposal to establish a Centre for Health Protection (CHP), including its institutional arrangements and functional branches, the priority areas and the implementation timetable, details of which were set out in the above Administration's paper.

3. Dr TANG Siu-tong asked the following questions -

(a) Whether an Administrative Officer at Staff Grade C (AOSGC) (at D2 rank) proposed to be appointed to supervise the operation of the Emergency Response and Information Branch under the CHP would be a generalist or otherwise;

(b) Whether adequate powers would be given to the CHP to ensure full co-operation from various sectors of the community, such as the Hospital Authority (HA), universities, private hospitals and medical practitioners, in the prevention and control of communicable diseases; and

Action

(c) What measures would be taken to ensure that the CHP, as part of the Department of Health (DH), would be accountable to the public.

4. D of H responded that the Head of the Emergency Response and Information Branch would be a generalist, in view of the multi-faceted and cross-disciplinary work nature of the Branch. In identifying the Branch Head, it was necessary to look beyond DH because many activities of that Branch, such as corporate planning, risk communication strategy, cross-disciplinary response, had no parallel in the Department. It was therefore considered best that this post be spearheaded by a generalist with broader exposure and experience and proven administrative and cross sectoral co-ordination skills.

5. Regarding Dr TANG's second question, D of H said that there was no need to use legislation to enlist full co-operation from the relevant stakeholders in the public health infrastructure for the prevention and control of communicable diseases as they were all acutely aware of the need to do so. Such a need was heightened, arising from the last Severe Acute Respiratory Syndrome (SARS) outbreak. In particular, the working relationship between DH and HA had been much improved. D of H further said that although he was empowered by the Quarantine and Prevention of Disease Ordinance (Cap. 141) (the Ordinance) to prevent and control infectious diseases of public health importance in Hong Kong, he rarely needed to invoke the Ordinance. This was because most of the prevention and control work were carried out by frontline medical practitioners. For instance, it was up to the attending doctor to decide whether a case warranted epidemiological investigation and whether the patient concerned needed to be isolated, etc. Nevertheless, in response to the comments made by the SARS Expert Committee that the Ordinance had not kept pace with modern developments, a review was being conducted by the Administration to ensure its adequacy in dealing with threats posed by infectious diseases.

6. As to Dr TANG's last question, D of H said that there was no cause for concern that CHP staff would not be held accountable for any mistakes made. Not only would CHP staff be governed by civil service regulations, those who were professionals would further be governed by the code of practice of their respective professional bodies.

7. Dr TANG Siu-tong further asked whether the review of the Ordinance would address the lack of information sharing between universities occurred during the last SARS outbreak. In response, Permanent Secretary for Health, Welfare and Food (PSHWF) said that this would be looked at by the Administration in the course of its review of the Ordinance.

Action

8. Ms LI Fung-ying noted that the following six functional branches would be created under the CHP -

(a) Surveillance and Epidemiology Branch;
(b) Infection Control Branch;
(c) Emergency Response and Information Branch;
(d) Public Health Laboratory Services;
(e) Public Health Services; and
(f) The Programme Management and Professional Development Branch.

The (ICB) Infection Control Branch would develop, promulgate and evaluate best practices in infection control at health care and non-health care settings, support epidemiological investigations of communicable disease outbreaks in hospitals and support training in infection control for all level of health staff. The Public Health Services would provide specialised clinical services (tuberculosis, HIV and sexually transmitted diseases) and would collaborate with hospitals and other clinical services on these three areas. In the light of this, Ms LI enquired whether the work of the ICB and the Public Health Services would overlap with that of HA's Hospital Infection Control Teams and hospital services. Ms LI pointed out that although a lack of a clear demarcation of responsibilities between the CHP and HA might not pose a major problem during normal times, it would certainly give rise to confusion during major outbreak of communicable disease.

9. D of H responded that the work of ICB would not overlap with that of HA's Hospital Infection Control Teams, as the responsibility of the latter was to implement the infection control protocol developed by that Branch. Accordingly, there was no question of any confusion occurring during major outbreak of communicable disease due to a lack of clear chain of command. D of H pointed out that as an integrated approach would be adopted by the CHP to control health hazards, infection control protocols for hospitals (both public and private) and other relevant entities (general medical practitioners, child care centres, homes for the elderly, etc.) would not be developed solely by ICB. In the case of the development of infection control protocol for public hospitals, it would be developed in tandem with professional staff experienced in infection control from HA, and other relevant organisations. HA staff seconded to work in the ICB would be remunerated by DH during their tenure at the CHP. D of H hoped that under such arrangements, HA staff deployed to work in ICB could help to promote an uniformed adoption of infection control practice in all HA hospitals when they returned to HA. As these staff would also receive training in field epidemiology during their tenure with ICB, they should also help to build the capacity and develop professional expertise of their colleagues on communicable diseases when they returned to HA. D of H further pointed out that the integrated approach to

Action

be adopted by the CHP should also work towards the integration of DH and HA information technology systems to provide a common platform for better information sharing and exchange.

10. D of H also said that there was no question that the work of the Public Health Services would overlap with the hospital services provided by HA. Despite the use of the term "clinical", D of H pointed out that the provision of specialised clinical services for tuberculosis, HIV and sexually transmitted diseases were provided by DH through its outpatient clinics/centres and should not be confused with hospital services. The main reason why specialised clinical services for tuberculosis, HIV and sexually transmitted diseases would continue to be provided by DH was because treatment of these conditions provided the best means of control. For instance, any efforts to control tuberculosis would be futile if directly-observed treatment could not be used on people suffering from the disease.

11. Ms LI Fung-ying expressed concern that HA staff deployed to work in ICB might be put in a very difficult position if HA disagreed with certain infection control guidelines drawn up by the Branch for HA to follow. In the light of this, Ms LI asked whether; and if so, what mechanism would be put in place to address such situation.

12. D of H responded that the situation cited by Ms LI in paragraph 11 above should not arise. Firstly, HA staff deployed to work in ICB would not carry their agenda in HA with them to their new posting. Secondly, the aim of ICB was to help HA, amongst others, to be more effective in its infection control work through the development, promulgation and evaluation of best practices in infection control, and not to dictate HA on how it should carry out its infection control work. Thirdly, the infection control protocol for public hospitals would be developed with input from HA staff seconded to work in ICB. Fourthly, both DH and HA had learnt from the experience of the last SARS outbreak the importance of forging a closer partnership in the prevention and control of communicable diseases. The re-alignment of the service boundary of DH Regional Offices with that of the hospital clusters of HA was a testament of the determination of both DH and HA to foster a closer working relationship. D of H further said that differences in opinions amongst health care professionals was a natural process in any debate on health issue, and should not be perceived as confrontational.

13. PSHWF supplemented that as what was planned might not necessarily work in practice 100%, HA would be advised to conduct drills to test whether the infection control protocol developed by ICB was effective and to ensure that all parties concerned were familiar with such. This would reduce any conflicts, if

Action

any, between HA and the CHP on the effective control of communicable diseases to a minimum. PSHWF further said that the setting up of ICB under the umbrella of CHP was to address the criticism made by the SARS Expert Committee about the lack of communication and collaboration between DH and HA exposed during the last SARS outbreak. It was hoped that through that Branch, a new culture of DH and HA joining forces to control infectious disease and health hazards could be developed and taken root.

14. Ms LI Fung-ying sought clarification as to whether DH would cease to provide elderly health services upon the establishment of CHP, having regard to the fact that such services did not appear in the proposed organisation chart of DH upon establishment of CHP in Annex B of the Administration's paper.

15. D of H clarified that elderly health services would be incorporated into personal health services under the Deputy Director of Health for Regulatory, Administration & Special Health Services, after the establishment of the CHP.

16. Dr LAW Chi-kwong said that it was difficult to tell from the structure of the proposed CHP how it would differ from what DH was presently doing. It was also unclear what the responsibilities and authority of the CHP were vis-à-vis those of HA. For instance, it was unclear whether ICB would replace the HA Central Committee on Infectious Diseases whose ambit included developing and promulgating overall policy on issues relating to infectious disease management and infection control throughout HA institutions. Another example was whether the Hospital Infection Control Team, which was responsible for day-to-day surveillance of infectious diseases in hospital and control of outbreaks would come under the direction of ICB, having regard to the fact that one of the core functions of the Branch was to support epidemiological investigations of communicable disease outbreaks in hospitals. Dr LAW further said that it was questionable whether the proposed CHP would have the capability to combat major outbreaks of communicable disease, in view of the fact that the recurrent costs of the CHP were expected to be largely funded by deployment of resources from DH. Although it was reckoned that a review of the Ordinance was still underway, Dr LAW was of the view that the Administration's paper should include whether; and if so, how the operation of the proposed CHP would be affected as a result of the review.

17. D of H responded that ICB would not replace HA Central Committee on Infectious Diseases. Under the integrated approach to control health hazards to be adopted by the CHP, HA Central Committee on Infectious Diseases would work closely with ICB to develop and set standards on infection control for HA hospitals to follow. HA had already set aside an area in the Princess Margaret Hospital (PMH) for ICB to set up a Centre of Infection Control. The Centre

Action

would serve as the focal point for developing standards and guidelines in infection control for all HA institutions, as well as for private hospitals and other relevant entities, such as general medical practitioners, child care centres and homes for the elderly. D of H further said that the creation of ICB under the umbrella of CHP would not bring the Hospital Infection Control Team of HA under the control of that Branch. Rather, the Hospital Infection Control Team would henceforth be required to see that the infection control protocol developed by ICB was adhered to as far as practicable in light of the circumstances of the hospital.

18. Although there was no question that the establishment of the CHP was a result of the restructuring of DH, D of H said that this was not merely a redeployment of resources and would entail fundamental changes to the existing way of communication and mode of operation. For instance, through its network, ICB would provide an opportunity to improve the communication of the relevant stakeholders in the public health infrastructure. Another example was that under the health protection programmes to be set up to cover a list of priority health hazards, experts from different agencies and disciplines would be brought in to work together and adopt a multi-disciplinary approach to controlling health hazards.

19. D of H further said that there was no cause for concern that the work of the proposed CHP would be restrained by it not having the necessary funding. D of H pointed out that given that the CHP workforce would mainly comprise DH staff, it was understandable that the recurrent costs of CHP would be largely funded by redeployment of resources from DH. The Hong Kong Jockey Club (HKJC) had pledged a donation of $500 million for the establishment of the CHP. The Administration would seek HKJC's support to deploy part of the donations to fund the costs for the new CHP facilities where appropriate. It would also seek support for funding the recurrent costs for the new additional staff for CHP. In the light of a review of the CHP's operation to be conducted in 2005, the Administration would further assess if there was a need to seek additional funding resources.

20. As regards the impact of the review of the Ordinance on the operation of the CHP, D of H said that due regard would be given to ensuring that the CHP would be able to effectively discharge its functions. It was envisaged that statutory powers of D of H, as now provided by the Ordinance, would eventually rest with the new health protection controller.

21. Dr LAW Chi-kwong asked whether the Hospital Outbreak Control Team, headed by the Cluster Chief Executive, would in future become obsolete, having regard to the fact that HA Central Committee on Infectious Diseases would in future integrate its work with that of ICB. Dr LAW further asked whether the

Action

Hospital Infection Control Team/Hospital Outbreak Control Team of HA would still be responsible for conducting field investigation in respond to outbreaks, or that such a task would also be undertaken by the Epidemiology and Infection Control Units under ICB to be set up in five hospitals in the hospital clusters of HA.

22. D of H responded that no decision had yet been made on whether the Hospital Outbreak Control Team should be retained after the establishment of the CHP. One possibility was for the work of the Hospital Outbreak Control Team to integrate with that of the Epidemiology and Infection Control Units (EICUs) of ICB. D of H however pointed out that the deletion of the Hospital Outbreak Control Team would not undermine the infection control work of HA, as day-to-day surveillance of infectious diseases in hospital and control of outbreaks would still rest with the Infection Control Team of each hospital. Under the existing arrangements, a Hospital Outbreak Control Team, evolved from a Hospital Infection Control Team, would only occur if an outbreak had evidence of significant spread in the hospital.

23. D of H further said that minor disease outbreak in hospital would continue to be handled by HA staff, and staff of EICUs could be enlisted to render support in conducting epidemiological investigations of disease outbreak if so requested by HA. D of H however pointed out that in times of major disease outbreaks, say, of a magnitude of the SARS outbreak last year, CHP would assume primacy with regard to surveillance, epidemiology and infection control of the disease concerned. For instance, apart from the staff of EICUs, staff of the Surveillance and Epidemiology Branch (SEB) would also be enlisted to conduct epidemiological investigations of disease outbreak. D of H further said that apart from the aforesaid, another function of ICB was to conduct audit of the infection control work carried out by HA, independent of the same presently conducted by HA. This added oversight should further help to enhance the effectiveness of infection control in HA.

24. Dr LAW Chi-kwong remained of the view that the demarcation of responsibilities between CHP and HA with regard to surveillance, epidemiology and infection control was far from clear, and urged that this be sorted out prior to the establishment of the CHP.

25. Miss CHAN Yuen-han expressed reservation about establishing the CHP as part of DH, having regard to the inability of DH to coordinate with HA and the Health, Welfare and Food Bureau (HWFB) in the management of the last SARS outbreak in Hong Kong.

26. PSHWF responded that despite the weaknesses in the current public health

Action

system to prevent and control communicable diseases, this did not necessarily mean that the proposed CHP should be established independent of the Government. In the Administration's view, a more pragmatic approach was to improve on the current system. As pointed out earlier at the meeting, the establishment of the proposed CHP would not merely be a restructuring of DH. The CHP would be a new public health infrastructure for consolidating existing diseases control strategies and address new challenges, such as emergency response to outbreak. It would not only have professional knowledge and expertise in combating communicable and non-communicable diseases, but also the administrative skills and statutory power to co-ordinate various government departments and the community when taking appropriate measures to tackle health threats and respond to outbreaks.

27. PSHWF pointed out that through an integrated approach to be adopted by the CHP in the performing of many of its activities, stronger partnerships with the healthcare professions, community, academics, government departments, national and international authorities in the control of communicable diseases would be established. For instance, the CHP would have a mixed staff with professionals from DH, HA and other relevant organisations through different engagement mechanisms. The CHP would work toward integrating the information technology systems of DH and HA to provide a common platform for better information sharing and exchange. Health programmes would also be newly set up to pool together experts from different agencies and disciplines to tackle priority health hazards. In addition to the provision of laboratory services and support of disease control by providing laboratory diagnosis and carrying out laboratory surveillance, the Public Health Laboratory Services under the CHP would develop partnership with laboratories in HA, Agriculture, Fisheries and Conservation Department, Government Laboratory, local universities and overseas agencies. With the structural revamp and enrichment/integration of resources, the CHP would be able to address the inadequacies in DH's existing interface with (i) the community; (ii) international and Mainland authorities; (iii) HA and private hospitals/practitioners and (iv) universities. The CHP would also enable the benefits of '3R's - real-time surveillance, rapid intervention and resolution and risk communication to be realised progressively.

28. PSWHF further said that the SARS Expert Committee recommended that the CHP should be set up within the Government and its existing public health infrastructure, since many of its core functions, such as collecting sensitive data from patients and contacts for medical surveillance purposes, requiring healthcare institutions to comply with directives, could not be performed effectively by non-government agencies. The Administration saw the merit for the setting up the CHP as part of DH which already performed some of the basic functions of a CHP and its staff were experienced in public health matters. The public health

Action

infrastructure and statutory authority for performing the health protection existed in DH. It was also noted that most of the CHP-like organisations set up in countries, such as Japan, New Zealand, Canada, Singapore and Finland, were government agencies or government owned entities. For instance, the renowned US CDC was a government agency under the Department of Health and Human Services.

29. D of H supplemented that there was no cause for concern that the fact that the CHP was a government agency its decisions would be influenced by political considerations. As mentioned earlier at the meeting, most of the work for the prevention and control of communicable disease were carried out by frontline medical professionals. Occasions where he would need to exercise his powers under the Ordinance would invariably involve major decisions, such as imposing an isolation order on a whole residential block. D of H however pointed out that given the openness and transparency of the Government, he could not see how such major decisions would not be made on grounds other than protecting the health of the public. Moreover, he himself, being a medical professional, was governed by the code of practice of his profession to protect public health.

30. Miss CHAN Yuen-han pointed out that it was unclear who was the decision-maker in isolating Block E of Amoy Gardens during the last SARS outbreak. In response, PSHWF said that D of H was the sole authority to exercise the public health legislation. This was in line with the practice of overseas jurisdictions. PSHWF further said that there was no question that D of H would exercise his power under the Ordinance for purposes other than protecting public health, as he would be held liable for any breach of authority under the Ordinance.

31. Dr LO Wing-lok expressed support for the establishment of CHP as part of DH. Dr LO however was of the view that adequate powers should be given to CHP and DH to enable them to carry out their work and that the demarcation of responsibilities and authority between CHP and HA should be made clear. Dr LO then asked the following questions -

(a) What was the reason(s) for naming the new public health infrastructure CHP and not "Centre for Disease Control and Prevention" as adopted in other places; and

(b) How many staff of ICB and SEB would come from DH and HA and whether they would be redeployed to at DH and HA again.

32. PSHWF explained that the reason why the Administration had elected to name the new organisaton as CHP was because it considered that the Centre, as it

Action

developed, should also have responsibility advising all aspects of health protection, including food safety and hygiene, veterinary issues, non-communicable diseases and their risk factors, etc. PSHWF pointed out that although the new structure was named CHP, the priority of the organisation was on the prevention and control of communicable diseases. This was in line with the recommendations of the SARS Expert Committee Report that a new CHP should be established within the Government to strengthen its capacity to prevent and control communicable diseases. PSHWF further said that in light of the need to provide physical accommodation, develop the information technology system and recruit experts and staff, it would take some time before all the Branches in the CHP would be fully in place. Of the six Branches highlighted in paragraph 6 of the Administration's paper, the establishment of the SEB and ICB were priority areas.

33. D of H said that the head of CHP would not be redeployed from CHP to other divisions of DH, as there was no other post in DH which was pitched at D4 as the head of CHP. Specialists of epidemiology and virology being recruited from overseas and the 20 public health doctors being recruited locally would also not be posted out of CHP to other posts in DH. This was to ensure that experience gained on public health protection would be retained by CHP. D of H however pointed out that there was no ruling out that some of the 20 public health doctors would be redeployed to other posts in DH on a temporary basis to enable them to meet the requirements of certain professional qualifications.

34. In summing up, the Chairman hoped that the Administration would have regard to members' views that the responsibilities and the authority of the proposed CHP should be made clearer. PSHWF undertook to do so in the Administration's proposal to seek the Establishment Subcommittee's endorsement to create the posts of the controller of CHP (D4) and the AOSGC (D2) to be offset by the deletion of one D4 post and one D3 post in DH. The other Branch Heads and directorate staff of the CHP would be identified through resource redeployment from DH and HA. PSHWF further said that the Administration would also make clear in its staffing proposal to the Establishment Subcommittee how the existing divisions of DH would be reorganised after the establishment of CHP.

III. Continue discussion on the commitment for the fight against SARS

(LC Paper No. CB(2)846/03-04(04))

35. Deputy Secretary for Health, Welfare and Food (DSHWF) briefed members on the Administration's proposal to further increase the commitment created for the fight against SARS by $230 million to $930 million. Subject to members' view, the Administration intended to seek funding approval from the Finance

Action

Committee (FC) on 20 February 2004.

36. Mr CHAN Kwok-keung noted that the additional funding required did not include the resources necessary for more permanent arrangements/features such as the resources necessary for implementing the recommendations of the SARS Expert Committee and the long-term implications of SARS on the mode of delivery of hospital services. In the light of this, Mr CHAN enquired about the estimated sum required to implement all of the 46 recommendations of the SARS Expert Committee.

37. DSHWF responded that as the recommendations of the SARS Expert Committee were very extensive and some, such as the re-organisation of HWFB would take a longer time to implement, the Administration had yet to conduct a comprehensive assessment on the amount of money required to implement all of these recommendations. DSHWF however pointed out that additional finding would be sought for such permanent features as the construction of an infectious disease centre at PMH. It was the Administration's plan to seek funding support from FC for the construction of an infectious disease centre at PMH in the coming one to two months' time.

38. Dr LAW Chi-kwong expressed support for the Administration's proposal to further increase the commitment against SARS by $230 million. Dr LAW however pointed out that some post-SARS measures, such as those mentioned in paragraph 7(b) to (e) of the Administration's paper, looked highly likely to become longer term and/or permanent features. In the light of this, Dr LAW enquired whether additional funding would be allocated to implement these measures after the money for funding them ran out. If the answer was in the negative, whether this meant that these measures would cease or not the costs of implementing them would be absorbed by HA which was already operating under a tight budget.

39. DSHWF responded that an additional funding of $400 million would be allocated to HWFB in 2004/05 to meet the recurrent expenditure of implementing infection control measures. It was the Administration's intention to brief members on the expenditure of HWFB after the Government's annual expenditure proposals for the next financial year had been finalised.

40. Dr LO Wing-lok noted that from paragraph 7(a) of the Administration's paper that over 1 000 staff, including some 100 doctors, were employed by HA during the last outbreak, and at present only about 500 of these extra staff (mainly registered nurses and supporting staff) remained with HA. In the light of this, Dr LAW enquired whether this meant that the some 100 extra doctors had left the employ of HA.

Action

41. Director, HA responded that apart from renewing the contracts of some of the 100 doctors during the last outbreak, HA had hired additional doctors in July 2003 to strengthen its manpower resources to better cope with any infectious disease outbreak. Director, HA further said that although he could not provide an accurate figure at the meeting, there was a net increase in the number of doctors hired by HA since the last outbreak. At the request of Dr LO and the Chairman, Director, HA undertook to provide information on the numbers and types of the over 1 000 extra staff who were hired during the last outbreak and had remained with HA.

Admin

42. Dr LO Wing-lok further said that in view of the fact that 40% of the operators of the residential care homes for the elderly were willing to purchase service from the Visiting Medical Officers (VMOs), it would not be a prudent use of resources for HA to foot the bill for these home operators. In response, DSHWF said that funding had been already been set aside for the VMO Scheme to operate until 2004/05. Nevertheless, the Administration would take into account Dr LO's view in its review of the Scheme in future.

43. Dr LAW Chi-kwong hoped that in reviewing the VMO Scheme, due regard would be given to the impact of the VMO Scheme on elderly attendance to the specialist outpatient clinics of HA.

44. In view of significant sum allocated to HWFB for the fight against SARS, the Chairman urged HWFB to exercise prudence and care in vetting funding applications for such purpose. DSHWF assured members that HA, DH and other relevant government departments were required to fully justify their funding requirements in their applications which were rigorously scrutinised by HWFB. The Secretary for Health, Welfare and Food approved the applications having regard to their relevance to the scope of the commitment and their relative priority. These points would be made clear in the Administration's funding proposal to FC for increasing the commitment for the fight against SARS by $230 million on 20 February 2004.

IV. Consultation Paper on Enduring Powers of Attorney
(LC Paper No. CB(2)524/03-04(03))

45. Introducing the above Consultation Paper, Senior Assistant Solicitor General (SASG) said that the Enduring Powers of Attorney Ordinance (Cap. 501) was enacted in 1997 to allow individuals to make advance provision for the management of their property and financial affairs in the event of their subsequent mental incapacity. Section 5(2)(a) required that an enduring power of attorney must be signed in the presence of a solicitor and a medical practitioner, and it must

Action

be in the form prescribed in the Schedule to the Enduring Powers of Attorney (Prescribed Form) Regulation. Since the Ordinance came into effect on 1 July 1997, only three enduring powers of attorney had been registered. This contrasted with the position in Ireland over the same period, where 312 enduring powers of attorney had been registered as at 30 April 2003. The contrast with the position in England was even more stark. In 2000 alone, 12 340 applications were made to register enduring powers of attorney, and the figure had risen each year since 1986. It had been suggested that the low take-up rate in Hong Kong might be caused at least in part by the cumbersome requirement that an enduring power of attorney be executed in the presence of a medical practitioner and a solicitor, which however was not required in other common law jurisdictions. In the light of this, members' views were sought on the proposal to remove the requirement under section 5(2)(a) that an enduring power of attorney be executed in the presence of a medical practitioner.

46. Dr LAW Chi-kwong wondered whether the relaxation of the requirement under section 5(2)(a), as proposed in the Consultation Paper, would indeed improve the take-up rate for enduring powers of attorney. Although he was not against the proposal, he nevertheless considered the basis for change unsound. Given the differing socio-cultural characteristics of Hong Kong from that of English-speaking countries, it was neither appropriate nor prudent to assume that the removal of the requirement that an enduring power of attorney be executed in the presence of a medical practitioner would improve the take-up rate in Hong Kong. Any case for change must be based on credible reasons and not mere hypothesis. One area worth examining was whether the low take-up rate for enduring powers of attorney in Hong Kong might be due to the guardianship arrangements provided under the Mental Health Ordinance (Cap. 136).

47. SASG responded that the Department of Justice had not looked into whether, and if so, how the guardianship provisions under the Mental Health Ordinance had attributed to the low take-up rate for enduring powers of attorney in Hong Kong, and would follow up. SASG however pointed out that the guardianship provisions under the Mental Health Ordinance could not serve the function of the Ordinance which was to create an enduring power for an attorney to manage the property and financial affairs of his donor who had become incapacitated. On the issue of culture, SASG surmised that some measures could be taken by the Administration to raise public awareness about the benefits of using enduring powers of attorney. Dr LAW Chi-kwong remarked that the social and cultural fabric of a society could not be easily changed by mere education.

48. Miss CHAN Yuen-han asked whether the Department of Justice (DoJ) had received any complaints from the public that the requirement under section 5(2)(a) had discouraged them from creating a deed for the enduring power of attorney.

Action

In response, SASG said that no such complaints had been received thus far. He hoped that the consultation exercise could throw some light on the reason(s) for the low take-up rate in Hong Kong.

49. Mr CHAN Kwok-keung asked whether DoJ had made any estimation on the number of applications to register for enduring power of attorney in Hong Kong, if the proposal to relax the requirement for creating the deed of enduring power of attorney was implemented. SASG replied in the negative, as any estimation would be mere speculation. SASG further said that although it might turn out that the take-up rate would remain low despite the requirement in question being relaxed, this should not preclude any justifiable efforts to make the enduring power of attorney more accessible to the public.

50. Dr LO Wing-lok expressed similar views about the necessity for the proposal. In response, SASG said that the Ordinance was passed for a reason. Although it was difficult to quantify why only a handful of enduring powers of attorney had been registered since the Ordinance came into effect on 1 July 1997, it was hoped that with the simplified procedure, and hence less cost involved, the take-up rate for the power would be improved. Dr LO disagreed that the presence of a medical practitioner in the signing of the deed creating the enduring power of attorney would entail a higher cost, as medical practitioners in Hong Kong were easily accessible and the fee for engaging them for such a task was not high.

51. In summing up, the Chairman urged DoJ to take into account members' reservations about the need to implement the proposal. Having regard to the fact that no member from the Panel on Administration of Justice and Legal Services was present at the meeting to give their views on the proposal, the Chairman said that DoJ should also seek that Panel's views before deciding on the way forward.

52. There being no other business, the meeting ended at 10:38 am.

Council Business Division 2
Legislative Council Secretariat
5 March 2004