立法會
Legislative Council

LC Paper No. CB(2)3255/03-04
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 19 July 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) Dr Hon David CHU Yu-lin, JP Hon Cyd HO Sau-lan Hon CHAN Kwok-keung, JP Hon CHAN Yuen-han, JP Dr Hon YEUNG Sum Dr Hon LAW Chi-kwong, JP Dr Hon TANG Siu-tong, JP Hon LI Fung-ying, BBS, JP
Members absent	:	Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP Hon Jasper TSANG Yok-sing, GBS, JP Hon Andrew CHENG Kar-foo
Public Officers attending	:	Items IV and V Mrs Carrie YAU, JP Permanent Secretary for Health, Welfare & Food Mr Thomas YIU, JP Deputy Secretary for Health, Welfare & Food (Health)

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Mrs Ingrid YEUNG
Principal Assistant Secretary for Health, Welfare & Food (Health) 2

Mr Ivan CHAN
Assistant Secretary for Health, Welfare & Food (Health) 2

Dr Beatrice CHENG
Senior Executive Manager (Professional Services)
Hospital Authority

Dr T H LEUNG
Deputy Director of Health

Dr Sarah CHOI
Acting Assistant Director of Health (Family & Elderly Health Service)

Item V

Dr Aylwin CHAN
Executive Manager (Medical Services Development)
Hospital Authority

Item VI

Mr Stuart M I Stoker
Secretary, Law Reform Commission of Hong Kong

Dr Lawrence LAI, JP
Deputy Chairman, Law Reform Commission's Sub-committee on Decision-making and Advance Directives in relation to Medical Treatment

Mr Sunny CHAN
Member, Law Reform Commission's Sub-committee on Decision-making and Advance Directives in relation to Medical Treatment

Ms Judy CHEUNG
Secretary, Law Reform Commission's Sub-committee on Decision-making and Advance Directives in relation to Medical Treatment

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Clerk in attendance	:	Miss Mary SO Chief Council Secretary (2) 4
Staff in attendance	:	Ms Amy LEE Senior Council Secretary (2) 8

I. Confirmation of minutes
(LC Paper No. CB(2)3072/03-04)

The minutes of meeting held on 17 May 2004 were confirmed.

II. Information papers issued since the last meeting
(LC Paper Nos. CB(2)2859/03-04(01) to (02), CB(2)2957/03-04(01), CB(2)2973/03-04(01) and CB(2)3105/03-04(01) to (02))

2. Dr LO Wing-lok noted from LC Paper No. CB(2)3105/03-04(02) on insurance coverage for employees of the Hospital Authority (HA) who contracted an infectious disease at work that HA had recently renewed its employees' compensation insurance for 12 months starting 1 July 2004. Dr LO asked whether the insurance coverage for HA employees included SARS-related employees' compensation claims by HA employees.

3. Deputy Secretary for Health, Welfare and Food (DSHWF) responded that as in the past, HA employees who contracted an infectious disease at work would be covered by the policy, if the infectious disease was a personal injury by accident arising out of and in the course of employment. As SARS was an infectious disease, HA employees who contracted the disease at work would be compensated. DSHWF however pointed out that HA would reimburse the insurance company for the compensation paid out to HA employees who contracted SARS at work.

4. Dr LO Wing-lok remarked that HA was in effect the underwriter for compensating its employees who contracted SARS at work. Dr LO wondered whether this was due to the fact that no insurance company was willing to insure against such because of the high risk involved or because the asking premium was too high.

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5. DSHWF responded that HA considered it more economical to reimburse the insurance company for the compensation paid to HA employees who contracted SARS at work than to pay the premium covering such.

6. Dr LO Wing-lok expressed concern that it would be very difficult for the private sector to procure insurance coverage for their employees who contracted SARS at work, given that even HA, which was far more financially well-endowed than the private sector, could not afford the premium concerned.

7. DSHWF responded that the concern raised by Dr LO Wing-lok in paragraph 6 above should not arise because the risk faced by HA was much higher than that faced by the private sector. To his understanding, all private hospitals and clinics had been able to procure the necessary employees' compensation insurance for all of their employees. DSHWF further said that he was optimistic that HA would be able to negotiate for a reasonable premium for employees' compensation insurance coverage for infectious diseases next time, as a result of the implementation of numerous measures for strengthening infection control in public hospitals.

III. Report of the Subcommittee to monitor the implementation of the recommendations of the SARS Expert Committee and the Hospital Authority Review Panel on the SARS Outbreak

(LC Paper No. CB(2)3061/03-04)

8. Members noted the above report and raised no query.

IV. Primary health care - current status and future development

(LC Paper No. CB(2)3105/03-04(03))

9. DSHWF took members through the above Administration's paper detailing the current status of primary health care offered by the public sector in Hong Kong and the directions of future development.

10. Dr LAW Chi-kwong called upon better coordination between the Maternal and Child Health Centres (MCHCs) of the Department of Health (DH) and the general out-patient clinics (GOPCs) of HA in providing better maternal and child health services. Dr LAW pointed out that as a result of the rationalisation of MCH services, the number of MCHCs would be reduced from the existing 50 to 38. For instance, clients of the MCHC in Tai O would need to travel a long distance to get their services due to the closure of that MCHC. On the other hand,

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after the transfer of DH's GOPCs to HA, HA had involved obstetrics and gynaecology and paediatric specialists, amongst others, to provide consultation service in some of the GOPCs.

11. DSHWF responded that it was the established policy of DH and HA to coordinate their services to ensure the provision of optimal services to the public. There was no plan to transfer MCHCs to HA. However, discussion was underway between DH and HA to see how best the GOPC in Tai O could provide child immunisation services and antenatal and postnatal care to the residents there. Deputy Director of Health (DDH) supplemented that DH was also in discussion with HA on enhancing collaboration in providing antenatal care to expectant mothers, such as promoting better exchanges of patients' information.

12. Dr LO Wing-lok said that the Administration should set down a FM specialist to population ratio to work out the estimated number of FM specialists required based on population projection, so as to ensure that there was no over supply of doctors in providing primary care. Dr LAW Chi-kwong also said that although it was understandable for HA to take up a major role in training FM specialists given its suitable infrastructure, there was a need to develop a strategy to ensure that these trainees would not be stuck with HA after acquiring their specialist qualification. If that was not the case, the present uneven distribution of workload between the public and private sector in the provision of hospital services would be repeated in the provision of primary medical care.

13. DSHWF responded that it was the Administration's intention to conduct a study on the number of family doctors required in providing primary medical care shortly. DSHWF further said that the Administration would be in a position to revert to the Panel on the progress made in promoting public/private interface on the provision of primary medical care in the next legislative session.

14. Ms LI Fung-ying asked whether DH had any measures to address the continuing prevalence of tuberculosis due to drug resistance.

15. DDH responded that an assortment of drugs would be used on tuberculosis patients who failed to respond well to conventional drugs. In addition, the causative bacteria would be cultured to find out the most effective treatment protocol. DDH further said that the infectivity of tuberculosis would generally cease within two weeks after the patients concerned were on the necessary treatment. Once these patients had ceased to pose a threat to others, they would be discharged from hospitals for follow-up at DH's Chest Clinics. Doctors at DH's Chest Clinics would continue to closely monitor the patients' response to the treatment and see that the patients diligently followed the therapy which could last for up to nine months.

16. Ms LI further asked whether consideration could be given to making it mandatory for patients suffering from tuberculosis to undergo treatment and requiring people to present a health card before they could gain access to such public facilities as the swimming pool.

17. DDH responded that the issue of making it mandatory for patients suffering from tuberculosis to undergo treatment was debated in the 1960s and 70s. In the end, it was concluded that there was no need to do so as the infectivity of the disease would cease two weeks after the patients were on the treatment. DDH further said that the existing arrangement of educating the public to refrain from using the public swimming pool if they suffered any infectious diseases was suffice. Moreover, staff working at the public swimming pools would look out for people who displayed such symptoms as skin infection, eye irritation and coughing.

18. Dr YEUNG Sum expressed support for placing more emphasis on the provision of primary health care. Dr YEUNG then asked the Administration to provide the following information -

(a) percentage of HA's fundings allocated for provision of primary health care as opposed to that allocated for provision of hospital services;

(b) training of FM specialists and their employment situation after completion of training; and

(c) provision of health services for women and elderly living in the community.

19. Responding to Dr YEUNG's first question, DSHWF said that although he did not have the exact figure in hand, the proportion of money set aside for provision of primary care had been on the rise in recent years and would continue.

20. Regarding Dr YEUNG's second question, Executive Manager (Medical Services Development), HA said that FM trainees had to undergo six years' training. The bulk of the first four years' basic training took place within HA while the remaining two years' higher training took place in the community. To his knowledge, these trainees had not encountered much difficulty in finding employment in the private sector to complete their last two years' specialist training. Since the launching of the new Community Geriatric Assessment Teams(CGATs)/Visiting Medical Officers collaborative scheme by HA last year, arrangement had been made for FM trainees to work on the CGATs so as to make

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them more employable by the private sector after they completed their basic training with HA.

21. As to Dr YEUNG's last question, DDH said that since the launching of the Cervical Screening Programme by DH in March 2004, cervical screening service was presently available in all of the 38 MCHCs and three Women Health Centres. Plan was in hand to introduce more women health services in more MCHCs in future so that each of the 18 districts would have one MCHC providing comprehensive women health services. DDH further said that a central registry called the Cervical Screening Information System was being developed to support multiple functions such as maintaining information on screening history and results, tracking utilisation and follow up, sending reminders, linking records across different providers, generating indicators for coverage and quality assurance. It was envisaged that when the system was launched, the general public, service providers and laboratories would be able to make registration through the system, which would in turn be able to generate calls to users for subsequent screening. The target completion date for the whole system was October 2004.

22. As regards health services to the elderly, DDH said that a total of 18 Elderly Health Centres and 18 Visiting Health Teams were currently operated by DH. The former provided clinic service of health assessment, physical check up, counselling, curative treatment and health education to the elderly, whereas the latter reached into the community and residential care settings to increase the health awareness of the elderly and their self-care ability.

23. At the request of Dr LAW Chi-kwong, Executive Manager (Medical Services Development), HA undertook to provide the numbers of FM trainees who found employment in the private sector and started their own practice after four years' basic FM training, and the number of FM trainees retained by HA after acquiring their specialist qualification.

(*Post-meeting note :* The Administration advised that 66 trainees have completed family medicine basic training in HA and 45 have started their own practice in the community. The remaining 21 have been retained to provide essential clinical service in HA.)

24. Dr LO Wing-lok expressed concern that DH's disease surveillance function had been undermined as a result of the transfer of all GOPCs to HA. This situation would be worsened if the operation of the GOPCs was contracted out to the private sector.

25. DSHWF responded that with the establishment of the Centre for Health Protection under DH in June 2004, Hong Kong's disease surveillance capability

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had been greatly enhanced. Nevertheless, the Administration would look into the concern raised by Dr LO in paragraph 24 above.

26. In concluding, the Chairman urged the Health, Welfare and Food Bureau to also collaborate with other policy bureaux, such as the Education and Manpower Bureau and the Environment, Transport and Works Bureau, in its efforts to step up provision of primary care.

V. Report on approved SARS-related fundings
(LC Paper No. CB(2)3105/03-04(04))

27. Permanent Secretary for Health, Welfare and Food (PSHWF) briefed members on the updated position of the use of SARS-related fundings approved since March 2003, details of which were set out in the above Administration's paper.

28. Dr YEUNG Sum said that from time to time there were complaints from recovered SARS patients that their applications for the special ex-gratia financial assistance under the Trust Fund for SARS were refused. Dr YEUNG asked why this was the case.

29. PSHWF responded that the special ex-gratia financial assistance under the Trust Fund for SARS was intended to help those recovered SARS patients suffering from longer-term effects and with financial needs. Applications for assistance under the Trust Fund for SARS were vetted and approved by a Committee chaired by a non-official and comprised a balanced mix of non-official members with relevant background and some official members. Applicants dissatisfied with the decisions of the Committee could bring their cases up to the appeal board whose membership also comprised persons from outside the Government. PSHWF pointed out that the main reason why some applications for assistance were turned down was because the individuals concerned were considered not in financial hardship, such as they had a paid full-time job and/or had received relief payment from their employers. Nevertheless, the Administration would step up educating the recovered SARS patients on the eligibility criteria for assistance under the Trust Fund for SARS and provide counselling to those unsuccessful applicants.

30. The Chairman asked about the progress made by the Administration on convincing the Kwai Tsing District Board (KTDB) that the construction of a new infectious disease centre attached to the Princess Margaret Hospital (PMH) would not pose a public health threat to people residing in the vicinity. In response, DSHWF said that KTDC had at last given their support for the project.

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Responding to the Chairman's further enquiry on the site of the second infectious centre, PSHWF said that the Administration had not yet decided on constructing another such centre. The Administration would review, with the enhancement of the isolation facilities in major acute hospitals, whether the limited resources should be deployed on constructing a second infectious disease centre or be deployed to other areas in need such as improving primary care.

31. Mr CHAN Kwok-keung asked whether additional funding would be allocated to HA for running the new infectious disease centre attached to PMH.

32. DSHWF responded that the additional recurrent cost for operating the new infectious disease centre attached to PMH would be deployed from within HA's own funding.

33. The Chairman expressed concern that the costly isolation facilities would be left idle when there was no infectious disease outbreak, and asked what actions would be taken by HA to put these facilities to good use then.

34. Senior Executive Manager (Professional Services), HA responded that the isolation facilities would be used for isolating patients with infectious diseases such as tuberculosis and cluster of pneumonia in normal times. The isolation wards could also be converted into general wards if there was a shortage of hospital beds.

35. On closing, the Chairman thanked DSHWF for his contributions to the Panel and wished him a happy retirement. PSHWF also took the opportunity to thank members for their hard work and dedication in scrutinizing numerous proposals and measures on combatting SARS.

VI. Consultation Paper on Substitute Decision-making and Advance Directives in relation to Medical Treatment

(LC Paper No. CB(2)3105/03-04(05)

36. Dr Lawrence LAI, Deputy Chairman of the Law Reform Commission's Sub-committee on Substitute Decision-making and Advance Directives in relation to Medical Treatment briefed members on the salient points of the above Consultation Paper.

37. The Chairman invited Dr LAI to explain the difference between euthanasia and advance directives.

38. Dr Lawrence LAI responded that the Sub-committee on Substitute

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Decision-making and Advance Directives in relation to Medical Treatment (the Sub-committee) did not support euthanasia. Advance directives was to allow patients to choose the treatment they wished to receive at a later stage when they were no longer capable of making such decisions, such as withholding artificial life-support procedures, rather than ending their life deliberately by some form of intervention.

39. Dr LAW Chi-kwong expressed support in principle that patients at risk of becoming comatose or ending up in a vegetative state should be allowed to choose the type of treatment they would receive when things took a turn for the worse or to authorise someone to make decisions for them when they became mentally incapacitated. Dr LAW agreed with the Sub-committee's view that legislating advance directives at this stage would be premature as the concept of such was still unfamiliar in Hong Kong. Dr LAW also agreed with the Sub-committee's recommendation of amending the definition of "mentally incapacitated person" for the purposes of application of Parts II, IVB and IVC of the Mental Health Ordinance (Cap. 136) to include persons who were comatose or in a vegetative state. Dr LAW however pointed out that what constituted a person to be in a comatose state should be clearly spelt out in the legislation.

40. Dr YEUNG Sum said that as the concept of advance directives was little understood by Hong Kong people, publicity campaign should be launched to promote public awareness and understanding of the concept of advance directives.

41. Ms LI Fung-ying expressed support for advance directives, but was concerned about the conflict between the attending doctor and the family members of the patient concerned if the latter disagreed with the treatment administered on their family member. Ms LI also asked about the cost to be incurred for implementing advance directives.

42. Dr Lawrence LAI responded as follows -

(a) the Sub-committee recommended that an advance directive would only be applied when a patient was in one of three major medical conditions : irreversible coma, persistent vegetative state or terminally-ill as diagnosed by the attending doctor's and at least one other doctor;

(b) it was the Sub-committee's view that the Government should play a role in promoting public awareness and understanding of the concept of advance directives, and should endeavour to enlist the support of the relevant bodies such as the Medical Council and HA in this information campaign;

(c) when disputes arose between attending doctors and patients' relatives over the patients' prior instructions or wishes as to their medical treatment, application might be made to the court for a decision. The Sub-committee however considered resorting to the court to resolve such issues was not ideal. Not only were court proceedings costly, the traditional courtroom atmosphere and the legal culture of adversarial proceedings might alienate and intimidate applicants. The Sub-committee was of the view that providing an agreed form of advance directive, as suggested in Annex I to the Consultation Paper, would reduce the likelihood of dispute uncertainty. The model form required two witnesses, one of whom should be a medical practitioner. Neither witness should have an interest in the estate of the person making the advance directive. The witness requirement was to ensure that no one would issue an advance directive without being made aware of the significance and consequences. The Sub-committee also recommended that those who wished to make an advance directive should be encouraged to seek legal advice and discuss the matter first with their family members. Family members should also be encouraged to accompany the individual when he/she made the advance directive; and

(d) the establishment of a central registry, accessible 24 hours a day, was recommended to be established for the safe-keeping of all advance directives and to enable the confirmation of any advance directives which had been made by an individual. Although the financial implications of the central registry had not been discussed in detail by the Sub-committee, it was envisaged that the operating costs involved should not be significant.

43. Miss CHAN Yuen-han said that more time was needed for the Panel to discuss the issue of advance directive, which, if no sufficient safeguards were built into the system, could have dire consequence on the persons making the advance directive. For instance, an individual might be influenced by unscrupulous persons into making an advance directive which was not in his/her best interests.

44. Dr Lawrence LAI responded that the chance of the situation mentioned by Miss CHAN in paragraph 43 above should not be high for the reasons given in paragraph 42(c) above.

45. Miss CHAN Yuen-han further said that the consultation period on substitute decision-making and advance directives in relation to medical treatment should be extended beyond 30 September 2004 to enable the incoming Panel

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members to have a thorough discussion on the issues.

46. Mr Stuart Stoker, Secretary of the Law Reform Commission responded that the Sub-committee would be happy to discuss with the Panel again in the next legislative session.

VII. Any other business

47. The Chairman thanked Dr LAW Chi-kwong, who had decided not to run for another term of LegCo office, for his contributions to the Panel. The Chairman also wished those members who decided to run for LegCo office every success in the coming September election.

48. There being no other business, the meeting ended at 10:40 am.

Council Business Division 2
Legislative Council Secretariat
30 August 2004