# 立法會
# *Legislative Council*

LC Paper No. CB(2)2087/00-01
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

**LegCo Panel on Health Services**

**Minutes of meeting**
**held on Monday, 11 June 2001 at 8:30 am**
**in Conference Room A of the Legislative Council Building**

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| **Members Present** | : | Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP (Chairman)<br>Dr Hon LO Wing-lok (Deputy Chairman)<br>Hon CHAN Yuen-han<br>Hon Bernard CHAN<br>Dr Hon YEUNG Sum<br>Hon Andrew CHENG Kar-foo<br>Hon LAW Chi-kwong, JP<br>Dr Hon TANG Siu-tong, JP<br>Hon LI Fung-ying, JP<br>Hon Michael MAK Kwok-fung |
| **Member Absent** | : | Hon Cyd HO Sau-lan |
| **Public Officers Attending** | : | All items<br><br>Mr Thomas YIU<br>Deputy Secretary for Health and Welfare<br><br>Mr Eric CHAN<br>Assistant Secretary for Health and Welfare |

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Ms Kinnie WONG
Assistant Secretary for Health and Welfare

Item V

Miss Joanna CHOI
Principal Assistant Secretary for Health and Welfare

Dr W M KO
Deputy Director, (Operations & Public Affairs)
Hospital Authority

Items VI and VII

Dr P Y LAM, JP
Deputy Director of Health

Miss Angela LUK
Principal Assistant Secretary for Health and Welfare 1

Item VI

Dr Elizabeth KWAN, JP
Consultant i/c Dental Service, Department of Health

Item VIII

Dr TSE Lai-yin
Consultant (Community Medicine), Department of Health

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

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

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**I. Confirmation of minutes of meetings held on 27 February, 9 April and 14 May 2001**
(LC Paper Nos. CB(2)1458/00-01, CB(2)1735/00-01 and CB(2)1736/00-01)

The three sets of minutes were confirmed.

**II. Date of next meeting and items for discussion**
(LC Paper Nos. CB(2)1737/00-01(01) - (02))

2. Members agreed to discuss the following issues at the next meeting to be held on 9 July 2001-

(a) Mental health service; and

(b) Manpower situation of public hospital nurses.

In respect of (a), members further agreed to invite members of the Panel on Welfare Services to attend the discussion of the item.

**III. Information paper issued since last meeting**
(LC Paper No. CB(2)1737/00-01(03))

3. Members noted the Administration's paper entitled "Comparison of Harvard Report recommendations and proposals in the Consultation Document on Health Care Reform" and raised no queries.

**IV. Draft report of the Panel for submission to the Legislative Council on 27 June 2001**
(LC Paper No. CB(2)1737/00-01(04))

4. Members endorsed the above draft report for submission to the Legislative Council on 27 June 2001.

**V. Rationalisation of Public Hospital Services**
(LC Paper No. CB(2)1737/00-01(05))

5. At the invitation of the Chairman, Deputy Director, Hospital Authority (DDHA) briefed members on the Administration's paper which detailed the

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existing clustering arrangement for public hospitals, the principles used for long term planning of public hospital services and the recent development of cluster management in the Hospital Authority (HA).

6. Ms LI Fung-ying noted that under the new cluster management structure, a cluster would be led by a Cluster Chief Executive who would assume overall responsibility for the operations of hospitals and services in the cluster, and be in charge of the cluster budget. In this connection, Ms LI enquired about the staffing impact if the new cluster management structure was implemented.

7. DDHA responded that there might eventually be staff reduction at the management level arising from the implementation of the new cluster management structure, having regard to the fact that managerial work and other supporting services could be further integrated under the new structure. DDHA further said that he did not envisage any reduction of frontline healthcare staff engaged in clinical work. There might, however, be areas of work which could give way to automation. DDHA assured members that any staff reduction would be carried out in a gradual manner to avoid any destabilising effect on staff.

8. Responding to Ms LI's further enquiry as to whether staff had been consulted on the implementation of the new cluster management structure, DDHA replied in the positive. DDHA further said that prior to selecting the Hong Kong East Cluster to pilot the new cluster management with effect from 1 June 2001, each cluster had widely consulted its staff through various briefings/meetings. Taking himself as an example, DDHA said that he had attended five to six such briefings/meetings organised by the cluster under his management during the past few weeks to listen to the views of frontline staff, which numbered between 200 to 300 on each occasion, on the new arrangement.

9. Mr Michael MAK asked the following questions -

(a) Whether the reason for implementing the new cluster management structure was to exert some degree of control on the Hospital Chief Executives, as HA felt that Hospital Chief Executives were presently given too much autonomy in the operation of the hospitals under their purview;

(b) Whether more senior posts would be created at the expense of frontline posts being cut as a result of implementing the new cluster management structure;

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(c) How would the new integrated cluster management structure differ from the management structure practised by the then Medical and Health Department; and

(d) Reason why there were more hospital clusters on Hong Kong Island (HKI) and Kowloon than in the New Territories (NT), and why some hospitals and institutions did not come under any cluster.

10. DDHA replied in the negative to Mr MAK's first question. He explained that the reason for implementing the new cluster management structure was to further improve integration and cooperation amongst hospitals within a cluster so as to enable better rationalisation of hospital services and facilitate the development of preventive and primary care. Although it had always been HA's intention to discourage competition and encourage collaboration amongst hospitals within a cluster, HA nevertheless hoped that the new cluster management structure would further help hospitals to move away from the existing hospital-based culture to a cluster-based culture or system wide culture.

11. Regarding Mr MAK's second question, DDHA said that the implementation of the new cluster management structure might result in a reduction of senior staff because of further streamlining of work at the management level. The reduction of such would, however, be taken forward in a gradual manner. As a first step, one of the Hospital Chief Executives within a cluster would be selected to assume the office of Cluster Chief Executive. DDHA further said that staff would not be laid off as a result of implementing the new cluster management structure, as given the vast size of HA and the fact that new services would come on stream in future, staff made redundant in a particular cluster because of rationalisation of services could be re-deployed to another cluster to perform the same type of work or take up a new one where training could be provided.

12. As to Mr MAK's third question, DDHA said that during the times when provision of hospital services was under the then Medical and Health Department, all major decisions were made at the headquarters level. Although district offices were set up to manage the operation of hospitals within the districts concerned, their duties were nevertheless limited to routine matters such as personnel administration and procurement of minor equipment. Such an arrangement was vastly different from the cluster management approach practised by HA whereby decision-making powers on how hospitals should be run were devolved to each Hospital Chief Executive who, in turn, was overseen by a Hospital Governing Committee (HGC). Under the new integrated cluster management structure, better rationalisation of hospital services and hence cost-effectiveness could be achieved

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as the Cluster Chief Executive would assume overall responsibility for the operations of hospitals and services and be in charge of the cluster budget.

13. As regards Mr MAK's last question, DDHA explained that the reason why there were more hospital clusters in HKI and Kowloon than in NT was because HKI and Kowloon had more hospitals than NT when HA took over public hospital services from the then Medical and Health Department more than 10 years ago. The reason for the greater number of hospitals on HKI and on Kowloon than on NT was because HKI and Kowloon were traditionally the most populous areas. Although there had been an exodus of people moving to NT since the 1980s, the pace of the opening of new hospitals still lagged behind that of population growth in NT as a lot of time was needed to plan and construct a hospital. On the question as to why some hospitals and institutions did not belong to any hospital cluster, DDHA explained that this was because they were for use by the whole community. For instance, the reason why the Grantham Hospital and the Hong Kong Red Cross Blood Transfusion Service were not under any hospital cluster was because the former was a specialist hospital providing comprehensive treatment of heart and lung diseases and the latter was used not only by HA hospitals but also by private ones.

14. Noting that Cluster Chief Executive would be in charge of the cluster budget, Mr Michael MAK enquired whether this meant that Hospital Chief Executives would no longer be in charge of the budget of the hospitals under their purview. DDHA responded that although the Cluster Chief Executive would be in charge of the cluster budget, decisions on how resources should be used amongst hospitals within the cluster would be made in consultation with the Hospital Chief Executives through a committee. It should however be noted that in deciding how resources should be used within a hospital cluster, the most important thing was to ensure that resources would be used in such a way so as to achieve the best health outcomes rather than dwelling on whether it was fair or unfair to a particular hospital within a cluster. DDHA pointed out that the HA Board, the HGCs and the Hospital Chief Executives were supportive of the creation of the Cluster Chief Executive post, as they recognised that hospitals presently lacked the impetus to re-deploy resources amongst themselves to improve the cost-effectiveness in the delivery of health care services because of the hospital-based culture and the fact that re-deployment of resources amongst hospitals would need the approval of the HGCs concerned. DDHA further said that the experience of the Hong Kong East Cluster would be reviewed after six months. With the successful implementation of the pilot scheme, the new cluster management structure could be rolled out to all the eight hospital clusters.

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15. Mr LAW Chi-kwong asked the following questions -

(a) Whether there would be public representation on the cluster management level, having regard to the fact that the chairmen and members of the HGCs were people outside HA and the Government; and

(b) How would the roles of the HGCs be changed with the implementation of the new cluster management structure.

16. DDHA responded that HA was well aware of the fact that the roles of the HGCs needed to be changed to complement the new cluster management structure. However, HA considered it better to try out the new cluster management arrangement on the Hong Kong East Cluster by appointing a Cluster Chief Executive as a first step with no change made to the roles of the HGCs for the time being. The reason for withholding such was because changing the roles of the HGCs was a complicated matter requiring further studies. To this end, HA intended to conduct a review of the roles of the HGCs. Opportunity would also be taken to review how the existing three Regional Advisory Committees could be re-structured to better align with all the eight hospital clusters.

17. Mr LAW further enquired whether the governing bodies of ex-subvented hospitals were agreeable to the impending changes in the roles of the HGCs. DDHA responded that they were generally supportive of such. Their only request was that in doing so, the roles of the ex-subvented hospitals in the cluster they served could be maintained as far as possible.

18. The Chairman declared interests that she had served as the chairman of the HGCs of several hospitals in the past and was currently the chairman of one of them. The Chairman said that the idea of introducing a more integrated cluster management structure did not come up suddenly, but was a natural progression on the development of cluster management, as hospitals within a cluster were becoming increasingly aware of the need to strengthen collaboration amongst themselves so as to better serve the people living in that cluster.

19. Mr Andrew CHENG referred to paragraph 8 of the Administration's paper which stated that the provision of acute and intensive care services and facilities should preferably be concentrated in one major acute hospital in a cluster. Where a cluster was historically served by more than one acute hospitals, there should be a differentiation of role and scope of services to be provided by each of the hospitals in question. Where there was an extensive geographical spread of population and facilities in a cluster, notably in NT, accident and emergency

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(A&E) services could be provided in more than one acute hospitals. Judging on the aforesaid, Mr CHENG said that it was unclear whether A&E services would indeed be provided in more than one acute hospitals in a NT cluster. In this connection, Mr CHENG enquired about the basis for determining the level of A&E services to be provided in a NT cluster. Mr CHENG further said the lack of specialist services in small hospitals had resulted in patients having to go from one hospital to another to get the appropriate treatment. There were complaints that some HA staff were not familiar with the types of services provided by other hospitals in its cluster, thereby delaying the patients from receiving proper medical care. He pointed out that even some ambulance personnel did not know which hospitals to send the patients to. He considered it important to publicise such information as taxi drivers needed to know where to take their passengers in emergency situations.

20. DDHA responded that notwithstanding the new cluster management structure, the provision of hospital services, including A&E services, in a cluster would always be based on the demand of people living in that cluster. In this connection, DDHA assured members that HA would not lightly close down A&E services in a particular hospital just to achieve cost saving. DDHA further said that HA would shortly review the performance indicators, which presently focussed on the quantity of services delivered, to include more indicators, such as unplanned readmission rate and frequency of complications, which could measure the effectiveness of services delivered. To complement the development of ambulatory and community care, consideration would also be given to devising a separate set of performance indicators in this regard. DDHA pointed out that due to resource constraints, it would not be possible to provide each hospital in a cluster with a comprehensive range of specialist services. Moreover, it would not be conducive to the training of medical staff if a specialist service only serviced a very small number of patients. Although not all hospitals would be provided with a comprehensive range of hospital services, there were established procedural guidelines in HA hospitals to facilitate inter-hospital transfer of patients. In general, doctors of the A&E Department would stabilise the condition of traumatic patients before considering the need for transfer to another hospital for further treatment. If a transfer was required, the attending doctor would base on the clinical judgment to decide which was the appropriate receiving hospital.

21. Noting that five hospital clusters, namely, the Hong Kong East Cluster, the Kowloon East Cluster, the New Territories South Cluster, the New Territories East Cluster and the New Territories North Cluster, were each presently provided with A&E services in more than one acute hospitals, Dr LO Wing-lok enquired which one of them would be selected to undergo rationalisation of hospital services along the lines set out in paragraph 8 of the Administration's paper, i.e. the provision of

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acute and intensive care services and facilities should preferably be concentrated in one major acute hospital in a cluster. Where a cluster was historically served by more than one acute hospitals, there should be a differentiation of role and scope of services to be provided by each of the hospitals in question.

22. DDHA responded that paragraph 8 of the Administration's paper merely outlined the ideal model of hospital service delivery. In this connection, DDHA clarified that HA would not arbitrarily close down A&E services in a cluster which had such services in more than one acute hospitals without regard to patients' need. Notably, A&E services could be provided in more than one acute hospitals in a cluster where there was an extensive geographical spread of population and facilities. A case in point was the New Territories North Cluster. In view of the fact that the population of Tuen Mun and Yuen Long would each reach 600 000 in the coming 10 years, it is likely that HA would continue to maintain A&E services in more than one acute hospitals in the New Territories North Cluster.

23. Noting that one of major planning parameters for the provision of hospital services was population, Dr LO further enquired whether consideration would be given to disallowing people living outside the geographical areas of a hospital cluster to use the hospital services in that cluster. DDHA responded that HA preferred to maintain the existing practice of letting people choose which public hospitals they wished to receive treatment, at least for the time being. DDHA however pointed out that although each cluster was targeted to serve the population living in that cluster, HA would also take into account the inter-cluster flow of patients due to factors such as patient preferences, location of a patient's work place and distribution of specialised services in different clusters in estimating the need for hospital services within a cluster.

24. Dr TANG Siu-tong declared interest as a member of the HGC of Tuen Mun Hospital. Dr TANG then asked whether, under the new cluster management arrangement, allocation of resources to each cluster would be based on the population of each cluster and that each cluster could independently decide its own provision of hospital services, including the provision of specialised services.

25. DDHA responded that if the new cluster management structure was to be implemented in all the eight hospital clusters, HA would consider using population and demographic profile as the basis for allocating resources to a particular cluster. As regards Dr TANG's second question, DDHA said that although each cluster would have considerable autonomy on the delivery of hospital services, HA Head Office would continue to play a major role in determining the need for hospital services within a cluster. In respect of the provision of specialist services for a particular cluster, DDHA said that the decision on such must be made at the Head

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Office level. HA had set up a committee to consider the provision of specialist services for a particular cluster. Views of outside experts would sometimes be sought if some proposed specialist services were complicated in nature.

26. Dr TANG Siu-tong expressed concern that if the allocation of resources to a cluster was population-based, a cluster might not get enough funding to provide a comprehensive range of hospital services which could cater to patients' needs if it had a relatively small population base. DDHA responded that there was no question of such a situation as HA planned to re-align the existing clustering arrangement to make the number of population of each cluster similar to one another before using population as the basis for allocation of resources. Responding to Dr TANG's enquiry as to the ideal number of hospital clusters, DDHA said that he could not give an answer at this stage. He however pointed out that it could not be ruled out that the number of hospital clusters could be reduced from the existing eight.

27. Dr YEUNG Sum expressed concern that the appointment of a Cluster Chief Executive would duplicate the work of the Hospital Chief Executives within the cluster. Dr YEUNG further expressed concern about the workability of the new cluster management structure as the HGCs of ex-subvented hospitals might not be willing to hand over their governing power over to the Cluster Chief Executive.

28. DDHA responded that there was no question of duplication of work between a Cluster Chief Executive and the Hospital Chief Executives in the cluster, having regard to the fact that the duties of Cluster Chief Executive were very clearly spelt out, namely, he/she would assume responsibility for the operations of hospitals and services in the cluster, and be in charge of the cluster budget. As mentioned earlier at the meeting, HA would make no changes to hospital governance at this stage, i.e. the Cluster Chief Executive would consult the HGCs and the Hospital Chief Executives before making decisions on the matters relating to hospital services. In the event that the new cluster management structure were rolled out to all hospital clusters, there was a need for HA to also rationalise the HGCs and the Regional Advisory Committees to make them complementary to the new structure. Regarding the concern raised by Dr YEUNG about the HGCs of ex-subvented hospitals reluctant to give up their governing power, DDHA said that there was no cause for such concern as HA would continue to manage these hospitals according to the provisions set out in the agreements made with the Boards of Directors of the organisations which owned these hospitals prior to the setting up of HA. In the event that rationalisation of hospital governance was called for, a new agreement would be made with the Boards of Directors of the organisations which owned the ex-subvented hospitals.

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## VI. Oral Health Services for the Elderly
(LC Paper Nos. CB(2)1459/00-01(07) - (08))

29. Deputy Secretary for Health and Welfare (DSHW) took members through the Administration's paper (LC Paper No. CB(2)1459/00-01(07)) which set out the Government's oral health and dental care policy and reported on the existing dental care services for the elders.

30. Mr LAW Chi-kwong then introduced his submission (LC Paper No. CB(2)1459/00-01(08)) which set out the findings of a survey conducted by the Democratic Party on the oral health of elders and the recommendations for rectifying the existing deficiencies in the provision of oral health for the elders. He highlighted the precarious oral health condition of the elders, for example, 18.5% of elders aged between 65 and 74 surveyed were without teeth and this was way below the 5% standard set down by the World Health Organisation, Mr LAW urged the Government not to wait for the results on the territory-wide oral health survey, but to expeditiously introduce measures which could improve the oral health of elders with little or no financial means in order that they could lead a happy and healthy retirement life. Mr LAW further said that the Government's oral health policy, which emphasised on promoting oral hygiene and oral health awareness, was of no use to the elders who had no teeth or their teeth had decayed so badly that immediate curative care was needed. In this connection, Mr LAW hoped that the Government would not apply the existing oral health policy indiscriminately across the board, and should devise a separate oral health policy for the elders.

31. Dr YEUNG Sum enquired whether consideration would be given to buying services from the non-governmental organisations (NGOs) which were presently providing dental care services, so as to help elders with little financial means, particularly those who were not eligible for Comprehensive Social Security Assistance (CSSA), to lead a happy and healthy retirement life.

32. DSHW agreed that good oral health was integral to the elders in having a healthy and happy retirement life. He assured members that it was not the intention of the Government to delay improving dental services for the elders. A case in point was that prior to the completion of the territory-wide oral health survey, action would shortly be taken to implement one of the proposals contained in the Consultation Document on Health Care Reform that the Government should take active steps to encourage more NGOs to provide affordable dental care services to the public on a self-financing basis. To this end, the Administration would identify and discuss with those NGOs which were capable of providing dental care

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services. As only 2 000 elderly CSSA recipients had received dental grants last year, publicity would be stepped up to make the elders and their family members more aware of the availability of the dental grants. In view of the aforesaid measures to be taken, DSHW said that the Administration considered it not necessary to buy dental services from the NGOs concerned.

33. Dr YEUNG said that encouraging more NGOs to provide affordable dental care services to the public on a self-financing basis was not entirely satisfactory, as elders of little financial means would still find the dental fees too expensive. Ms LI Fung-ying concurred with Dr YEUNG. DSHW explained that given resources constraint, it was incumbent upon the Government to use public funds in areas where the best health outcome could be achieved. Therefore the funds available would be used to improve the oral health of the population by promoting oral hygiene and oral health awareness in the community and facilitating the proper use of oral care services. In this connection, the Administration could only at this stage commit itself to the measures set out in paragraph 8 (c) and (d) of its paper. DSHW, however, agreed to convey members' concern and suggestions for further consideration by the Administration.

34. In view of the poor oral health of many elders, the Chairman suggested that the Administration should conduct a review of the effectiveness of its public education on oral hygiene and oral health.

35. Dr LO Wing-lok enquired what the "CSSA designated dental clinics" referred to in paragraph 8(e) of the Administration's paper were. Dr LO further enquired about the work of the 11 designated clinics .referred to paragraph 3 of the same paper.

36. Responding to Dr LO's first question, Deputy Director of Health (DDH) said that to his understanding, the CSSA designated dental clinics were appointed by the Social Welfare Department (SWD) and that they were run by NGOs. DDH further said that CSSA recipients provided with dental grants were not bound to use the dental care services provided by these CSSA designated dental clinics, and could choose private dental service providers if they so wished. However, should CSSA recipients opt for treatment by private dental providers, SWD would only provide a dental grant equivalent to the amount which would be charged by the CSSA designated dental clinics for the same treatment. As regards Dr LO's second question, DDH said that the 11 designated clinics referred in paragraph 2 of the Administration's paper were government clinics providing dental services for civil servants and their dependents. These clinics would set aside some sessions during the week to provide emergency services to the public. DSHW supplemented that 800-odd quotas were provided to the public by these 11 designated clinics every

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week. The Administration would shortly explore the possibilities of providing more emergency dental services at these 11 designated clinics, say, by extending their operating hours etc.

37. Mr Michael MAK criticised that the oral hygiene and oral health education conducted by the Government had not greatly raised public awareness in this regard. In this connection, Mr MAK urged the Government to step up action in this regard as education was the most effective tool to prevent people from getting tooth decay and other oral diseases. Mr MAK then enquired about the progress made in identifying those NGOs which could provide affordable dental care services to the public on a self-financing basis.

38. DSHW responded that the Government attached great importance to promoting oral hygiene and oral health to the public. As a result of the enhanced efforts in this endeavour during the past 10 years, the general oral health of this generation had greatly improved. In this connection, DSHW believed that oral health of the elders of the next generation should be much better than the current elders. On the question of the progress made in identifying those NGOs which could provide affordable dental care services to the public on a self-financing basis, DHSW said that work in this regard had not yet commenced, but would likely start in the latter part of this year.

39. Miss CHAN Yuen-han echoed members‘ views expressed at the meeting, and urged the Government to provide more assistance to enable elders who were not CSSA recipients to get proper dental treatment if needed. DSHW reiterated that the Administration would seriously consider members’ views for providing better oral health services for elders of little financial means.

40. Responding to Dr TANG Siu-tong's enquiry as to whether the Administration would set a list of prices for those NGOs providing dental care services to the public on a self-financing basis, DSHW reiterated that the Administration had not commenced work in identifying those NGOs which were capable of providing dental care services. However, if the green light was given to the Administration to proceed with the aforesaid, prices would certainly be a matter for discussion.

41. In view of members’ grave concerns about the lack of oral health support for elders of insufficient means, Mr LAW Chi-kwong strongly urged the Administration to expeditiously set oral health goals for the elders and implement measures to achieve such.

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**VII. Proposed Creation of Supernumerary SPEO Post in Department of Health**
(LC Paper No. CB(2)1737/00-01(06))

42. DSHW introduced the Administration's paper which proposed to create a supernumerary post of Senior Principal Executive Officer (SPEO) (D2) in DH for 24 months to coordinate necessary preparatory and planning work related to the Health Care Reform. DDH highlighted the justifications for the creation of the proposed post, which were detailed in paragraphs 3 to 6 of the Administration's paper.

43. Responding to the Chairman's enquiry about the date for submitting the proposal to the Establishment Subcommittee of the Finance Committee for consideration, DSHW said that the Administration planned to do so on 20 June 2001.

44. Miss CHAN Yuen-han expressed strong reservation about the proposed creation of a supernumerary SPEO post in DH, given that one of the major responsibilities of the post was to set up a Complaint Office in DH, which was at variance with members' request for a medical complaint system independent of the Government. DSHW assured members that there was no question of such a situation. Although it was mentioned in the Consultation Document on Health Care Reform that a Complaint Office should be set up in DH, the Administration had not started work on formulating the detailed implementation plan. In view of the public concern over the patient complaint system, the Administration had decided to carry on with the discussion with various parties concerned, including the Subcommittee on improvements to the medical complaints mechanism of the Panel, until a consensus was reached before implementing the reform measures.

45. Mr Michael MAK also expressed reservation about the proposal and queried the reason for pitching the post at D2 and not D1 level. DDH said that the complexity and the sensitivity of the tasks required of the post warranted an officer with extensive administrative experience, strong leadership skills and vision. He/she should be able to work with parties of divergent interests, set workable plans, communicate effectively at all levels and supervise a wide span of work within a tight timeframe.

46. Noting that the reason for creating a supernumerary SPEO post in DH for 24 months was to coordinate necessary preparatory and planning work related to the Health Care Reform, Dr LO Wing-lok queried why such a post was not created earlier, say, when drawing up the Consultation Document on Health Care Reform. Dr LO further queried why the post was an Executive Officer grade post and not

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an Administrative Officer or professional grade post. It appeared to him that the Administration already had a candidate in mind and the SPEO post was tailor-made for the person concerned. Responding to Dr LO's first question, DSHW said that the reason for creating a supernumerary SPEO post in DH at this stage was because DH needed to start planning work for taking on a more important role in health advocacy and reducing its emphasis on provision of direct curative services. As regards Dr LO's second question, DDH said that the reason why the proposed post was an Executive Officer grade post was because the major functional responsibilities of the post-holder fell within the scope of work of an executive officer. For example, the job of the SPEO post would entail a lot of liaison and coordination work, assessment of financial and staffing implications, and review of related legislation, etc.

47. In view of the wide range of duties of the proposed SPEO post outlined in paragraph 7 of the Administration's paper, Ms LI Fung-ying enquired whether additional staff would be required to help the directorate officer concerned in carrying out his/her duties. DDH responded that staff would be re-deployed within DH for the purpose. Should the green light be given to implement the various proposals contained in the Consultation Document on Health Care Reform relating to DH, additional staff might need to be recruited arising from re-organisation of DH.

## VIII. Any other business

Recent cholera cases

48. Consultant (Community Medicine) briefed members on the recent cholera cases and the actions taken by the Administration to protect public health. Although cholera occurred in Hong Kong from time to time, for example, a total of 71, 18 and 12 cholera cases occurred in 1998, 1999 and 2000 respectively, it was nevertheless quite unusual to have six cholera cases notified within a one-week span from 4 to 8 June 2001. The six patients comprised five women and one man aged between 21 and 61. Two of them lived on HKI, while the remaining four lived in the Kwai Tsing district. They were all admitted to Princess Margaret Hospital and were presently in stable condition. All six patients had not travelled outside Hong Kong during the incubation period and the cases were classified as local ones.

49. To identify possible sources of the disease, DH had joined forces with the Food and Environmental Hygiene Department (FEHD) in this regard. On FEHD end, its staff had gone to the food establishments and markets which the six

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patients had patronised during the five days before they got inflicted with cholera to conduct investigation. On DH end, an analysis of the DNA fingerprinting of the bacteria found would be conducted. To date, the sources of the disease had not been identified. However, there was no evidence that there was any linkage between the six cholera cases.

50. Although there was no sign of the spreading of cholera in Hong Kong, FEHD had already stepped up surveillance of markets and food establishments across the territory, including food establishments with fish tanks to ensure that their fish tanks met the requisite hygiene standards. FEHD also took the opportunity to educate operators of the food establishments and markets about the importance of food safety. To better prepare departments concerned in preventing the occurrence of cholera as summer approached, DH had convened an inter-departmental meeting in April 2001. Another such meeting would be convened shortly to strengthen the work of departments concerned in preventing and combating cholera.

51. Responding to Dr YEUNG Sum's question on when the Administration could find out the source of cholera, Consultant (Community Medicine) said that she could not give a definite answer, as time was needed to visit all the food premises which the six patients had patronised during the five days before they got afflicted with cholera. DDH supplemented that it was very difficult to find out the source of cholera. To his knowledge, only once had the source of the disease been found. DDH added that the best way to prevent cholera and other food-borne diseases was by observing good personal, food and environmental hygiene at all times.

52. Miss CHAN Yuen-han expressed concern that the six recent cholera cases, unlike the cholera cases of the past, were local ones and occurred in various districts of Hong Kong. In this connection, Miss CHAN urged the Administration to expeditiously find out the source of the disease. Miss CHAN further said that the Administration should step up publicity to raise public awareness about the need to observe good personal, food and environmental hygiene well in advance of the summer season, in order to prevent catching cholera and other food-borne diseases. Consultant (Community Medicine) responded that during the past years, the number of cholera cases being classified as local and overseas cases were half and half respectively. Consultant (Community Medicine) further said that DH had stepped up publicity to raise public awareness about the need to observe good personal, food and environmental hygiene to order to prevent cholera and other food-borne diseases since March/April this year.

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53. Dr TANG Siu-tong enquired whether Hong Kong had to be declared a cholera infected area, having regard to the fact that six cholera cases had occurred within one week. Dr TANG further enquired when the results of DNA fingerprinting test would be available and whether there was any linkage between the six cholera cases.

54. DDH responded there was no need to declare Hong Kong as a cholera infected area, as Hong Kong had adequate facilities, such as good sewage disposal, water supply, and health care systems, to cope with the situation. Moreover, there was no sign of the spreading of cholera in Hong Kong. As to when the results of the DNA fingerprinting test would become available, DDH said that preliminary results should be available later this week. Regarding Dr TANG's last question, Consultant (Community Medicine) said that the six patients had not patronised the same food establishments or markets.

55. Noting that fish tanks were presently required to be equipped with ultra-violet light or ozonated water to kept them clean, the Chairman enquired whether bacteria which could give rise to cholera had been found in these fish tanks. DDH replied in the negative.

56. Dr LO Wing-lok expressed support for FEHD to confiscate food which failed to meet hygiene standards in order to protect public health. Although source of cholera could not be found through such efforts, it was nevertheless very effective in stamping out further occurrence of cholera cases. In this connection, he urged FEHD to step up actions to smash illegal meat roasting factories and unlicensed food establishments, and confiscate food kept and sold in unhygienic conditions.

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

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