立法會
Legislative Council

(Revised)

LC Paper No. CB(1) 1768/01-02
(These minutes have been seen by the Administration)

Ref : CB1/PL/EA/1

LegCo Panel on Environmental Affairs and
LegCo Panel on Health Services

Minutes of joint meeting
held on Wednesday, 20 March 2002 at 8:30 am
in the Chamber of the Legislative Council Building

Members present : Members of the LegCo Panel on Environmental Affairs

Hon CHOY So-yuk (Chairman)
* Hon Cyd HO Sau-lan (Deputy Chairman)
Ir Dr Hon Raymond HO Chung-tai, JP
* Hon CHAN Yuen-han, JP
Hon SIN Chung-kai
Hon Miriam LAU Kin-yee, JP
Hon Emily LAU Wai-hing, JP
* Hon LAW Chi-kwong, JP
Hon Abraham SHEK Lai-him, JP
Hon Henry WU King-cheong, BBS
* Hon Michael MAK Kwok-fung
Hon LAU Ping-cheung
Hon Audrey EU Yuet-mee, SC, JP

Members of the LegCo Panel on Health Services

Dr Hon LO Wing-lok (Deputy Chairman)
Hon CHAN Kwok-keung
Dr Hon TANG Siu-tong, JP
Hon LI Fung-ying, JP

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Members absent : Members of the LegCo Panel on Environmental Affairs

Hon Martin LEE Chu-ming, SC, JP
Hon WONG Yung-kan
Hon LAU Kong-wah
Hon Tommy CHEUNG Yu-yan, JP

Members of the LegCo Panel on Health Services

Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP (Chairman)
Dr Hon YEUNG Sum
Hon Andrew CHENG Kar-foo

(*Also members of the LegCo Panel on Health Services)

Public officers attending : Environment and Food Bureau

Mr Donald TONG
Deputy Secretary (B)

Ms Annie CHOI
Principal Assistant Secretary (B)2

Environmental Protection Department

Mr Patrick LEI
Principal Environmental Protection Officer (Waste Policy)

Mr Conrad LAM
Principal Environmental Protection Officer (Special Waste)

Mr David HA
Senior Environmental Protection Officer

Department of Health

Dr Thomas CHUNG
Principal Medical and Health Officer

Hospital Authority

Dr CHOY Khai-meng
Executive Manager (Professional Services)

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Clerk in attendance : Miss Becky YU
Chief Assistant Secretary (1)1

Staff in attendance : Mrs Mary TANG
Senior Assistant Secretary (1)2

I Election of Chairman

As Mrs Sophie LEUNG, Chairman of the Health Services Panel, was away from Hong Kong, Miss CHOY So-yuk, Chairman of the Environmental Affairs Panel, took the chair for the joint meeting.

II Outcome of consultation on the Clinical Waste Control Scheme

(LC Paper No. CB(2)1845/99-00(01) — Administration's paper on "Report on Dioxin Emissions"

LC Paper No. CB(2) 1845/99-00(02) — "An Assessment of Dioxin Emissions in Hong Kong – Summary of Findings"

LC Paper No. CB(2) 1845/99-00(03) — "An Assessment of Dioxin Emissions in Hong Kong : Final Report" by Environmental Resources Management

LC Paper No. CB(2) 1845/99-00(04) — "Review of Dioxin Emissions in Hong Kong - Summary of Findings"

LC Paper No. CB(2) 1845/99-00(05) — "Review of Dioxin Emissions in Hong Kong" by Professor Christoffer RAPPE

LC Paper No. CB(1) 1323/01-02(01) — Background brief prepared by the Legislative Council Secretariat

LC Paper No. CB(1) 1323/01-02(02) — Information paper provided by the Administration)

2. The Deputy Secretary for the Environment and Food (B) (DSEF(B)) briefed members on the revised proposal for the Clinical Waste Control Scheme (CWCS) by highlighting the salient points in the information paper. The Senior Environmental Protection Officer then gave a power-point presentation on the findings and recommendations of the study report on treatment technologies conducted by Mr William K TOWNEND, a renowned international expert on clinical waste management.

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Management and collection of clinical waste

3. Given the small amount of clinical waste produced by an average clinic, Dr TANG Siu-tong said that it would not be cost effective to arrange for daily collection and disposal of waste. However, any accumulation of infectious clinical waste, in particular surgical dressings containing blood and pus, would not be desirable and measures would need to be worked out to prevent infection. The Principal Assistant Secretary for the Environment and Food (PAS/EF) said that used syringes and sharps could be kept in boxes pending collection. Hence, an accumulation of clinical waste for a maximum period of three months was allowed. While waste producers were required to consign their waste to licensed clinical waste collectors, some flexibility was allowed for healthcare professionals to deliver not more than 5 kilogrammes (kg) of clinical waste to the Chemical Waste Treatment Centre (CWTC) or authorized collection points set up by waste collectors or individual waste producers subject to the approval of the Director of Environmental Protection. She also drew members' attention to sections 4 and 5 of the "Draft Code of Practice for the Management of Clinical Waste for Small Clinical Waste Producers" at Annex A to the Administration's paper (LC Paper No. CB(1) 1323/01-02(02)) which set out the code of practice for segregation, packaging, labelling and storage of clinical waste. She said that there had been consultation with stakeholders on the practicability of the code of practice and how clinical waste should be properly handled.

4. Miss CHAN Yuen-han asked whether consideration could be given to setting up collection points at Government clinics or public hospitals to facilitate disposal of waste generated by small waste producers, in particular by clinics at remote locations or outlying islands which were not served by clinical waste collectors. In reply, DSEF stressed that the user-pays principle should apply in waste collection and taxpayers should not bear the collection cost. Besides, if Government were to set up collection points at Government clinics or public hospitals to serve small waste producers, it would be seen to be competing with private waste collectors.

5. Referring to section 3.3 of the consultation document on the proposed CWCS at Annex A to the paper, Mr MAK Kwok-fung expressed concern about the restrictions imposed on healthcare professionals who chose to carry small quantities of clinical waste to the licensed disposal facilities. They were not allowed to take public transport and only registered professionals could be entrusted with the delivery of these waste. He opined that this would pose difficulties in the delivery process, particularly for those clinics which employed unregistered nurses since they would have no choice but to engage the service of waste collectors. DSEF stressed the need for safety in the transport of clinical waste which might pose a threat to public safety. It was therefore imperative that such waste should not be allowed to be carried in public transport other than ferries. By the same token, the transport of waste had to be entrusted to registered professionals as they would be more experienced in handling the clinical waste in case of accidents during the transfer. Mr MAK noted with concern that the disposal of clinical waste generated by diabetes patients and others convalescing at home was left out in the

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revised CWCS. DSEF confirmed that there were practical difficulties in applying CWCS to waste generated at home and hence would not cover this in the proposed scheme.

Financial implications

6. Dr TANG Siu-tong enquired about the basis upon which the charge of $35 per month or about $1 per day for disposal of clinical waste by an average clinic was arrived at. PAS/EF said that the disposal cost referred to was in fact the treatment cost of clinical waste at CWTC. It was the Administration's intention to recover 31% of the variable operating cost as a start, gradually raising it to full recovery. At present, the variable operating cost for CWTC to treat clinical waste was estimated to be $7.7 per kg. This meant a charge of less than $3 per kg or less than $35 each month for an average clinic that produced 0.4 kg of clinical waste each day. She added that the disposal cost was to be added on to the existing collection charges which, according to the information provided by existing clinical waste collectors and private medical practitioners that were using their service, ranged from $30 to $300 per month. DSEF supplemented that the level of collection cost would vary depending on the rate of waste generation, frequency of disposal and location of the clinical waste producers.

7. Since the revised CWCS was based on a user-pays principle with a view to creating an economic incentive for waste reduction and segregation, Ms LI Fung-ying considered that the Administration should also recover the capital and fixed operating cost of CWTC through disposal charges. DSEF explained that CWTC was initially constructed to treat chemical waste. To encourage chemical waste producers to use the facility, it was agreed at the outset that the capital and fixed operating cost would not be charged. The same principle should similarly apply to clinical waste which was proposed to be treated at CWTC as well. He however reiterated that it remained the Administration's intention to recover the full variable operating cost of $7.7 per kg in the long run.

8. Dr LO Wing-lok declared interest as President of the Hong Kong Medical Association and representative of the medical constituency. He noted that much progress had been made on CWCS since it was first proposed in 1997, and that the medical profession had generally accepted the Scheme. While congratulating the Administration for its achievements so far, he enquired about the difference between fixed and variable operating costs and the time table for full recovery of the latter. PAS/EF explained that fixed operating cost related to the fixed cost for operating CWTC irrespective of the treatment load while variable operating cost referred to the actual cost incurred from the treatment of waste. When the proposed CWCS was first introduced in 1997, the Administration intended to recover the full variable operating cost by 2003-04. However, due to economic and other considerations, the cost recovery rate had been maintained at 31% in the past few years.

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9. Given that the Hospital Authority only accounted for 3.3 tonnes of the total eight tonnes of clinical waste produced each year, Dr LO enquired about the sources of the remaining waste. PAS/EF advised that the remaining clinical waste was generated by Government clinics, private hospitals and clinics as well as other small clinical waste producers. She also confirmed that the Hospital Authority would be required to shoulder the cost for treatment of clinical waste at CWTC.

Licensing of clinical waste collectors

10. Noting that the revised CWCS had proposed the establishment of a statutory licensing framework to regulate the handling of clinical waste by collectors and disposal facility operators, Dr TANG Siu-tong sought information on the licensing requirements. Ms LI Fung-ying also asked whether the nine existing waste collectors would be able to meet these requirements. The Principal Environmental Protection Officer (Waste Policy) advised that to facilitate a better understanding of the proposed statutory licensing framework which would be modelled after that for chemical waste collection, a number of meetings had been held with the nine existing waste collectors. They were advised to make suitable improvements to their service so as to comply with the licensing requirements which would likely come into operation in two years' time. It was hoped that the existing collectors would be able to meet the new requirements, and that more collectors could be licensed to handle clinical waste.

Treatment of clinical waste

11. Ms Cyd HO opined that consideration should be given to segregating clinical waste so that cytotoxic drugs, human tissue and body parts, pharmaceuticals and chemicals which should be incinerated could be separated from other clinical waste. She suggested that instead of incineration which was a source of dioxin emission, less polluting treatment methods such as thermal disinfection should be used to treat the latter. PAS/EF advised that as most of the thermal disinfection processes required pre-treatment shredding, this would pose occupational safety hazards to workers. Besides, vapour would be formed during the process, and residual chemicals and volatile organic compounds in the waste that could not be destroyed under low temperature would be vaporized and escape into the environment. There had been cases in the United States where workers who operated these treatment facilities contracted infectious disease. Therefore, the review concluded that thermal disinfection was not yet a satisfactory treatment method at the moment. Notwithstanding, the use of alternative treatment methods could be considered in the light of further advancement in treatment technologies.

Public consultation

12. Ms Emily LAU said that she was glad that the medical sector had finally accepted the revised CWCS which had been dragged on for years. However, there might be a need to solicit support from green groups and residents concerned on the revised CWCS.

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DSEF said that the Advisory Council on the Environment (ACE) was scheduled to discuss the revised CWCS at its meeting on 26 March 2002. Where necessary, meetings with the relevant District Council would be held to alleviate residents' concerns. Ms LAU noted that Greenpeace was staunchly opposed to the choice of incineration. As Greenpeace was not represented at ACE, she considered it necessary to consult Greenpeace also. At members' request, the Administration undertook to inform members of the outcome of discussion of ACE and District Council.

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13. Mr SIN Chung-kai said that Kwai Tsing residents had all along been objecting to the proposed retrofitting of CWTC for the purpose of handling clinical and other waste. Residents were concerned about the emissions associated with waste incineration and in fact there had been two past incidents where the level of dioxin emission had exceeded the permitted limits. He pointed out that when CWTC was first commissioned in 1990 in the then industrial district of Tsing Yi, it was intended to treat chemical waste from industrial undertakings nearby. In view of the environmental impacts of CWTC on the Tsing Yi population which had now grown to 0.2 million, Mr SIN asked if it would be more acceptable in the longer term to reprovision CWTC to a place which was far from human habitation. DSEF said that the Administration was well aware of the concerns of Kwai Tsing residents and had been closely monitoring the ambient air quality within the area. Treatment of clinical waste at CWTC was considered more efficient and cost-effective as it would be able to utilize the spare capacity of the existing facility. The proposed establishment of a separate treatment centre for clinical waste would be a long and costly process as environmental impact assessments and consultation exercises would have to be conducted for the selected site. Moreover, CWTC was well equipped to treat clinical waste in an environmentally acceptable manner. The Administration would continue its efforts to monitor the development of alternative treatment technologies apart from incineration. On dioxin emission, DSEF said that the amount of dioxin generated by incineration of clinical waste would be very low given the low PVC content of about 3% by weight of clinical waste.

Studies on dioxin

14. Referring to the consultancy study on dioxin emissions commissioned by the Administration, Ms Emily LAU enquired about the progress of the recommended food surveillance programme and monitoring of dioxins on soil, dust and vegetation in the vicinity of the existing and future facilities. PAS/EF said that the recommendations in the consultancy study had largely been implemented. The Environmental Protection Department had been monitoring dioxin levels in the vicinity of waste treatment facilities. Findings indicated that the dioxin level was comparable to other areas in Hong Kong. The Food and Hygiene Department had also been conducting food surveillance programmes on imported and locally produced food on a regular basis and results indicated that the level of dioxin was within acceptable limits. At members' request, the Administration undertook to provide information on the findings of the food surveillance programme and the results of the monitoring studies on dioxin emissions.

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15. On Ms Cyd HO's enquiry about the research study on dioxin content in human bodies undertaken by the Hong Kong University under Government sponsorship, PAS/EF said that the study was expected to complete in early 2003 and members would be informed of the findings in due course.

Way forward

16. On the need for a further meeting to follow up the subject, Ms Emily LAU said that this would depend on the Administration's reply to the concerns raised and the public response to the revised CWCS. In this connection, she suggested soliciting public views via the LegCo website. She also concurred with Mr SIN Chung-kai that funds for retrofitting CWTC should not be sought before the passage of legislation governing the implementation of the Scheme. Given that the Administration had all along been advocating the use of incineration in the treatment of clinical waste, Ms Cyd HO considered that members might need to hold another meeting to invite views from deputations regarding the practicability of other treatment options before reaching a decision. While expressing concern that there would be possible delays in implementing the Scheme if funding for retrofitting CWTC was not secured in time, DSEF agreed to provide the information requested by members and to consult the District Council on the revised CWSC before reverting back to the Panel. Mr SIN opined that there should be ample time for application of funding for the retrofitting works after passage of the legislation given the considerable lead time required to implement a number of administrative steps such as licensing of waste collectors before the coming into operation of the Scheme. To facilitate future discussion, the Chairman requested the Administration to provide the relevant time tables for the proposal and more information on dioxin emissions from CWTC.

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III Any other business

17. There being no other business, the meeting ended at 9:45 am.

Legislative Council Secretariat
4 June 2002