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LC Paper No. CB(2)2384/08-09
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 11 May 2009, at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, JP (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon Fred LI Wah-ming, JP Hon Andrew CHENG Kar-foo Hon Albert CHAN Wai-yip Hon Audrey EU Yuet-mee, SC, JP Hon Vincent FANG Kang, SBS, JP Hon Alan LEONG Kah-kit, SC Hon Cyd HO Sau-lan Hon CHAN Hak-kan Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou
Member attending	:	Hon WONG Kwok-hing, MH
Public Officers attending	:	Item III Dr York CHOW, SBS, JP Secretary for Food and Health Mr Patrick NIP, JP Deputy Secretary for Food and Health (Health)1 Dr Thomas TSANG Controller Centre for Health Protection Mr Shane SOLOMON Chief Executive Hospital Authority

Items IV-V

Professor Gabriel M LEUNG, JP
Under Secretary for Food and Health

Miss Gloria LO
Principal Assistant Secretary for Food and Health (Health)2

Dr CHEUNG Wai-lun
Director (Cluster Services)
Hospital Authority

Item IV

Dr Albert LO Chi-yuen
Cluster Chief Executive
New Territories West Cluster
Hospital Authority

Dr CHUNG Kin-lai
Hospital Chief Executive
Castle Peak Hospital and Siu Lam Hospital
Hospital Authority

Ms Margaret TAY
Chief Manager (Integrated Care Programs)
Hospital Authority

Mr Donald LI
Deputising Chief Manager (Capital Planning)
Hospital Authority

Item V

Dr Deacons YEUNG
Chief Project Coordinator (Doctor Work Reform)
Hospital Authority

Mr Linus FU
Manager (Doctor Work Reform)
Hospital Authority

Clerk in attendance : Miss Mary SO
Chief Council Secretary (2) 5

Staff in attendance : Miss Joanne FONG
Senior Council Secretary (2)6

Ms Maisie LAM
Senior Council Secretary (2)7

Ms Sandy HAU
Legislative Assistant (2)5

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I. Information paper(s) issued since the last meeting

Members noted a submission dated 17 April 2009 from 為下一代運動 expressing views on the prevention and control measures on human avian influenza infection and pandemic preparedness issued since the last meeting, and did not raise any queries.

II. Items for discussion at the next meeting

(LC Paper Nos. CB(2)1476/08-09(01) and (02))

2. Members agreed to discuss the following items at the next meeting scheduled for 8 June 2009 -

(a) North Lantau Hospital Project - Phase one;

(b) Updates on the Drug Formulary of the Hospital Authority; and

(c) Progress of licensing under the human reproductive technology.

III. Prevention and control of human swine influenza infection in Hong Kong

(LC Paper Nos. CB(2)1505/08-09(01) and (02), CB(2)1524/08-09(01))

3. Secretary for Food and Health (SFH) briefed members on the latest situation and measures being taken by the Government to prevent and control the spread of human swine influenza (HSI) in Hong Kong, details of which were set out in the Administration's paper (LC Paper No. CB(2)1505/08-09(01)). SFH and Controller, Centre for Health Protection (Controller, CHP) supplemented as follows -

(a) as of today, a total of 65 suspected cases were reported to the Centre for Health Protection and only one patient tested positive for HSI. Regarding the global situation, there were 4 871 confirmed cases of HSI as at 5:00 am, 11 May 2009. As Hong Kong had only one imported case and there had been no community transmission, the Administration would continue to take containment measures to delay the spread of HSI to the community;

(b) three passengers on board the Northwest Airlines flight no. NW 025 arrived in Tokyo from Canada via the United States (US)

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on 8 May 2009 were confirmed to have been infected with HSI. Based on the lists provided by the health authority in Japan and the Airline, 12 passengers on flight NW 025 who had entered Hong Kong had been located. Amongst these 12 passengers, eight of them were placed under quarantine in public hospitals, and four of them were subject to medical surveillance as they sat at a different cabin of the flight and did not share common facilities with the three patients. All these passengers had so far tested negative for HSI. The Immigration Department (ImmD) was still checking whether a passenger who had indicated to the Airline that he would come to Hong Kong had arrived in Hong Kong. Another passenger who had entered Hong Kong had yet been located;

(c) the Administration would maintain close communication with the Ministry of Health regarding the first suspected case of HSI in the Mainland involving a man travelled from US to Beijing through Tokyo via NW 029. He arrived in Beijing on 9 May 2009 and flew to Chengdu on Sichuan Airlines flight no. U8882 on the same day. In the event that the man was later confirmed as a case of HSI, the Administration would ensure expeditious information exchange about whether any passengers on flight NW 029 had come to Hong Kong; and

(d) the Administration would refine the disease control strategy for HSI and the management of contacts of confirmed HSI cases, having taken into consideration local data and experience in handling the first HSI case and new findings outside Hong Kong, and an announcement would be made in this week. New knowledge gained showed that (i) the mutability of the HSI virus appeared to be fairly limited so far; (ii) HSI virus was sensitive to both oseltamivir (Tamiflu) and zanamivir (Relenza); (iii) seasonal influenza vaccine conferred no protection against the HSI virus; (iv) HSI virus was more contagious than seasonal influenza. Its reproductive rate was greater than 2, i.e. each single primary case would generate more than two secondary cases on average, but that of seasonal influenza ranged from 1.5 to 1.7; and (v) HSI recorded a hospitalisation rate at about 5%, which was similar to that of seasonal influenza. The fatality rate of HSI appeared to be not high outside Mexico, with only five fatal cases reported in the US and Costa Rica and all were related to co-morbidity of underlying chronic diseases such as diabetes and asthma.

Turnaround time for the Polymerase Chain Reaction test

4. The Chairman asked about the turnaround time for the Polymerase Chain Reaction (PCR) test for rapid diagnosis of HSI infections.

5. SFH responded that PCR tests for HSI were conducted by the laboratories of the Department of Health (DH) and the University of Hong Kong. The two

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laboratories had the capacity to perform 1 000 and 600 tests per day respectively and test results would be available within six hours. Measures would be taken to expedite the collection of respiratory specimens from patients and shorten the delivery time to the laboratories.

Screenings at country entry and exit points

6. Mr WONG Kwok-hing commended the drastic measures adopted by the Administration in handling the first HSI confirmed case. He also expressed his appreciation to all frontline health care workers, Police officers, members of the Civil Aid Service, staff of the Food and Environmental Hygiene Department and other personnel for their hard work in this regard. Mr WONG then asked what measures would be taken by the Administration to guard against the import of the disease from the affected places, in particular North America.

7. Ms Audrey EU said that despite the implementation of stringent port health measures in Hong Kong, some affected places such as US did not adopt a policy of containment and no screenings were conducted at country entry and exit points to detect if people who were ill were travelling. She considered that the Administration should bring the issue up for discussion at the World Health Organization (WHO) and request these countries to measure the body temperature of all outbound travellers at the exit points so as to contain the spread of infection. Mr Fred LI, Dr PAN Pey-chyou and Mr Albert HO expressed a similar view. Dr PAN suggested that having a fever as well as other flu-like symptoms should be the criterion for barring persons suspected of having contracted HSI from getting onboard.

8. SFH responded as follows -

(a) more than 10 000 inbound travellers, including 5 600 from North America and others from the neighbouring Asian countries, on average per day entered Hong Kong. WHO's recommendation was that imposing travel restrictions would have very little effect on stopping the virus from spreading, but would be highly disruptive to the global community. Countries adopting measures that significantly interfered with international traffic, such as refusing country entry or departure to a traveller, must provide WHO with the public health reasoning and evidence for their actions;

(b) containment measures had and would continue be taken by the Administration to delay the spread of HSI to the community. A series of port health measures had been put in place to enable early detection of imported cases at points of entry, for example, health advice messages were broadcasted on board flights arriving Hong Kong, all inbound travellers were required to complete and submit health declaration forms, travellers from affected places found to have flu-like symptoms would be further assessed, ImmD staff at the airport would also clarify with the travellers holding the passport of the affected places their health

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conditions, health education pamphlets were distributed to travellers at all boundary control points and face masks would be provided to travellers from North America;

(c) Consul Generals of different countries had been informed of the containment measures currently implemented in Hong Kong and they had indicated support for these measures. Notwithstanding, not every place outside Hong Kong considered port health measures and taking body temperature of all incoming and departing travellers at airport and border control points an effective means to prevent outbreak of HSI. For countries in North America and Europe where local transmission of HSI became significant, containment was no longer appropriate and feasible and mitigation was a more appropriate approach; and

(d) not everyone infected with HSI would develop fever. According to data in hand, only about 60% of people infected with HSI had fever. Hence, merely prohibiting persons having a fever from travelling was not an effective way to guard against HSI.

9. Mr Andrew CHENG considered that all incoming passengers, particularly those from North America, should be required to remain in the aircraft after landing in Hong Kong to facilitate checking by DH staff to see if they had fever and flu-like symptoms. Ms Cyd HO expressed similar views, and pointed out that this could facilitate identification of contacts of the infected.

10. SFH said that dispatching DH staff to check the health conditions of passengers onboard a plane would unavoidably cause a delay to the passengers concerned. In addition to the measures mentioned in paragraph 8(b) above, airlines had been advised that their cabin crew should inform the port health authority of any suspected case, prior to the airplane's landing in Hong Kong. Where necessary, the airlines would provide the Administration with the names and contact addresses and/or numbers of all passengers bound for Hong Kong to facilitate contact tracing.

11. While expressing appreciation to the swift response of the Administration in containing the spread of HSI, Dr PAN Pey-chyou, Mr Vincent FANG and Mr IP Kwok-him asked the Administration whether it would request airlines to instruct their cabin crew to measure the body temperature of passengers on board the aircrafts bound for Hong Kong. SFH agreed to bring the issue up for discussion with the airlines.

12. Mr Vincent FANG asked about the air flow in the aircraft, given that good ventilation could help remove the HSI virus and reduce the chance of contracting the infection. Controller, CHP responded that the number of air changes per minute would be no less than 20 in an aircraft for dilution of contaminants. In addition, a high efficiency particulate air filter was installed in all aircrafts for removing air-borne particles and filtering out viruses.

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Management of contacts of confirmed HSI cases

13. Ms Audrey EU said that the Administration should clearly define the circumstances under which contacts of confirmed HSI cases should be put under quarantine or medical surveillance. She also enquired about the reason for tracing all passengers on board NW 025 who had entered Hong Kong and the management of contact of contacts.

14. SFH and Controller, CHP made the following response -

(a) as mentioned earlier, the Administration was reviewing the strategy and management of HSI. Plans for contact tracing and management of contacts under different settings would be devised based on the risk of the contacts of acquiring infection from the case-patient. The determination of whether there was such a risk depended on a host of factors, such as the distance between the person and the patient, the time they had stayed together, and the air flow of the setting;

(b) factors that had been taken into account in deciding to trace all passengers on board NW 025 who had come to Hong Kong included (i) NW 025 was a long-haul flight; (ii) the three patients were sitting in different rows of the economy class; and (iii) there might be more confirmed HSI cases apart from the three cases reported earlier on by the health authority in Japan; and

(c) as for the contacts of those contacts who had tested negative for HSI, such as the guests and staff of the hotel at which one of the passengers on board NW 025 had stayed, their risk of being infected was zero.

15. In response to Ms EU's further enquiry about the legal basis for placing a person under medical surveillance, quarantine and isolation respectively, SFH said that the Director of Health was empowered under the Prevention and Control of Disease Regulation (Cap. 599A) to do so.

16. Mr Albert CHAN was of the view that only those contacts who had a high likelihood of acquiring infection from the confirmed patient should be put under quarantine, taking into account the experience of the first HSI case that none of the quarantined persons had been tested positive with the virus.

17. SFH explained that the fact that the viral load of the first confirmed HSI case was relatively low and that he had received treatment at an early stage had made the risk of infecting others to a reasonably low level. However, according to findings in Mexico, US and Canada, contacts had 18-45% chance of getting infected. The Administration would, based on both local data and experience in handling the first HSI case and findings outside Hong Kong, devise plans for contact tracing and management under different settings. Mr IP Kwok-him said that contacts of confirmed HSI cases in a hotel setting should be placed under

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quarantine in an isolation centre instead of the hotel, so as to keep the disruption to the business operation of the hotel concerned to the minimal.

18. Mr Vincent FANG was concerned about the cost involved in placing the Metropark Hotel under isolation. SFH responded that the Administration was in discussion with the Hotel on the cost to be borne by the Administration.

19. In response to Mr Albert CHAN's enquiry about whether the Administration would consider using vacant units in public rental housing estates to accommodate quarantined persons or as temporary quarters for healthcare workers if situation warranted, SFH said that the Administration would keep in view the development to assess if there was a need to make such arrangements.

20. Mr Fred LI said that respiratory droplet of patients, which was the predominant transmission mode for the HSI virus, could only travelled a short distance (approximately one meter) through the air. In the light of this, he enquired about the reason for putting air passengers sitting in the same row and three rows in front and three rows behind the first confirmed patient under quarantine. SFH responded that the determination of contact in an aircraft would have to take into account the seat arrangement. The seating of the flight in question was in a 3-3 arrangement. Hence, passengers sitting in the same row and three rows in front and three rows behind were at risk of infection.

21. Dr PAN Pey-chyou said that the Hospital Authority (HA) should ensure that sufficient information would be collected from patients developing flu-symptoms for tracing later on if required. SFH responded that this would be done without compromising the privacy of the patients.

Health declaration arrangement at the boundary control points

22. Mr Fred LI enquired why it was not until 7 May 2009, six days after the confirmation of the first imported case of HSI on 1 May 2009, that health declaration arrangement was fully implemented at all boundary control points. Mr Andrew CHENG raised a similar question.

23. SFH explained that it took time for the Administration to deploy the necessary manpower and communicate with the authority in Shenzhen before the implementation of the health declaration arrangement at all boundary control points. Hence, priority had been accorded to the land boundary with higher patronage, such as Lo Wu.

Resources of HA to fight against HSI

24. Mr CHAN Hak-kan asked whether the manpower of the Accident and Emergency (A&E) Departments of public hospitals was sufficient for the imminent threat of a pandemic, taking into account that the HSI virus could be more virulent or severe during the coming winter influenza season. The Chairman was concerned about the manpower resources of Princess Margaret Hospital (PMH) in particular.

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25. Chief Executive, HA (CE, HA) responded that all public hospitals had been requested to review their staff deployment plan to ensure that they were well prepared to fight against the onslaught of HSI. As regards the manpower resources of PMH, CE, HA said that PMH had sufficient manpower to meet operational needs. The service demand for PMH in areas other than the A&E Department had in fact recorded a decrease in the last week.

26. Dr PAN Pey-chyou asked HA whether it had adequate supply of personal protective equipments (PPEs) to each cluster/hospital. CE, HA said that HA had a central stockpile of PPEs which were distributed among the clusters. For face masks, a new order of 13, 14 and 20 million had been placed for May, June and July 2009 respectively to meet the increase in utilisation.

27. Dr PAN Pey-chyou noted that one of the measures HA Headquarters had put in place was not to deploy pregnant staff to high risk areas. He sought clarification from HA on what constituted a high risk area. CE, HA advised that it was in general referring to the isolation wards, but the intensive care unit was also classified as a high risk area in some hospitals.

Vaccine and antiviral drugs

28. Mr WONG Kwok-hing asked whether the new vaccine against the HSI virus would become available in time to safeguard the health of the public in the coming winter influenza season. SFH responded that the development of a new HSI prototype vaccine, which could take three to four months, was underway. In the meantime, the Administration had contacted the vaccine manufacturers that Hong Kong would order the new vaccine once it became available. It should also be noted that Tamiflu remained an effective chemoprophylaxis against HSI so far.

29. Dr LEUNG Ka-lau noted that the antiviral drugs had been mobilised for chemoprophylaxis of hotel guests and staff of the Metropark Hotel. He asked whether the current stockpile of antiviral drugs was sufficient to serve the dual purpose of providing treatment for patients, and preventing HSI.

30. SFH responded that the Administration had stockpiled about 20 million doses of antiviral drugs to prepare for emergency situations and new orders had been placed to prepare ahead for possible HSI pandemic. At present, about half of the stock was for the use of health care workers for the purposes of post-exposure prophylaxis and chemoprophylaxis during a pandemic.

Providing medical care to healthcare workers and other personnel on duty

31. Dr LEUNG Ka-lau was of the view that an amendment should be made to the Employees Compensation Assistance Ordinance (Cap. 365) to include HSI as a prescribed occupational disease, in order to provide better protection to frontline health care workers. SFH agreed to consider Dr LEUNG's suggestion.

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32. Ms Audrey EU requested the Administration to ensure that members of the Civil Aid Service were provided with adequate medical care should they contract HSI in the course of their duties. SFH responded that persons infected with HSI during their working under the instruction of the Administration would be provided with medical care. Ms Cyd HO said that the medical care should also cover the contract staff working for government departments and HA.

Promotion of personal and environmental hygiene

33. Mr CHAN Hak-kan said that the Administration should include personal hygiene in the curriculum of kindergartens and primary schools and promote the concept to the public on a continuous basis via announcements of public interest.

34. SFH responded that efforts had been and would continuously be made by the Education Bureau to encourage schools to ensure the observance of personal hygiene measures so as to guard against the spread of influenza and other communicable diseases. SFH also called on the Legislative Council Members to render their support to the Administration's efforts in engaging the public to maintain personal and environmental hygiene to prevent pandemic disease. A dedicated website "The Fight against Pandemic Disease" had also been launched on 6 May 2009 to provide daily updates to members of the public.

35. Mr Andrew CHENG noted from paragraph 5(c) of the Administration's paper that mobilising the community to step up disease prevention effort was one of the Administration's strategies for preventing and controlling HSI. He asked what measures would be taken by the Administration in this regard.

36. SFH said that apart from the some 80 activities which took place during "Clean Hong Kong Day" on 10 May 2009, about 200 activities would be rolled out in the coming two weeks to heighten the community's vigilance on personal, home and environmental hygiene. In addition, all 18 District Councils had each been provided $500,000 to enhance cleansing at the district level.

37. Mr Albert CHAN said that public toilets should be provided with sensor activated hand-washing faucets for promoting hand hygiene to guard against the transmission of communicable disease. SFH responded that efforts would be made to improve the hand-washing facilities of public toilets if necessary.

Conclusion

38. In closing, the Chairman said that the Administration should take into account the views/concerns expressed by members in deciding on the way forward to contain the spread of the HSI virus to the community.

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IV. Relocation of Siu Lam Hospital to Block B of Castle Peak Hospital
(LC Paper No. CB(2)1476/08-09(03))

39. Ms Cyd HO noted that upon the proposed relocation of Siu Lam Hospital (SLH) to Block B of Castle Peak Hospital (CPH), the existing building in SLH would be retained for other services. She asked whether the Administration would take heed of the views at the district level in deciding the types of services to be provided.

40. Under Secretary for Food and Health (USFH) responded that HA would consider the appropriate types of services to be provided having regard to the demand in the district as well as the space available and the accommodation requirements in other types of services. The Administration welcomed any suggestion from members.

41. Dr PAN Pey-chyou expressed support for the proposed relocation of SLH to CPH. He then asked HA whether the transportation needs of the staff after the relocation had been taken care of. Cluster Chief Executive, New Territories West Cluster, HA said that the CPH was more accessible by means of public transport when compared to SLH. The proposed relocation would save the travelling time for many staff of SLH who were living in Tuen Mun and Yuen Long.

42. Dr LEUNG Ka-lau asked the following questions -

(a) whether HA had made any early planning for the future use of the wards at Block B of CPH when it was developed some ten years ago, and if so, why the wards were not ready for use but required renovation which, together with other improvement works, would cost about $320.3 million in money-of-the-day prices; and

(b) whether the site of SLH would be returned to the Government for the construction of private hospitals.

43. Responding to Dr LEUNG's first question, USFH said that Block B of CPH was completed under the first phase of the redevelopment of CPH in 1996. With the approach of increasing the emphasis on community based services and the enhanced provision of such services, space in ten wards at Block B of CPH had become available for alternative uses. Renovation of these wards and external areas in the vicinity was necessary as they were originally not designed to suit the special needs of severely mentally handicapped adult patients. Deputising Chief Manager (Capital Planning), HA supplemented that it would cost more than 1 billion should SLH was to be redeveloped in-situ to improve its facilities to meet the prevailing standards.

44. As regards Dr LEUNG's second question, USFH said that convenience was an important consideration for the selection of site for the construction of private hospitals. Given the isolated location of SLH, the Administration considered it more appropriate to retain the existing building in SLH for other

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services upon the proposed relocation of SLH to CPH.

45. In closing, the Chairman said that members of the Panel were in support of the proposed relocation of SLH to Block B of CPH.

V. Interim review outcome of pilot Doctor Work Reform programmes
(LC Paper Nos. CB(2)1476/08-09(04) to (06))

46. USFH and Director (Cluster Services), HA (Director (CS), HA) briefed members on the outcome of the interim review of the pilot doctor work reform programmes implemented by HA, details of which were set out in the Administration's paper (LC Paper No. CB(2)1476/08-09(04)).

47. Dr PAN Pey-chyou referred members to the submission concerning the long continuous work hours of frontline doctors of public hospitals (LC Paper No. CB(2)1476/08-09(06)). He considered it unreasonable for HA to require frontline doctors taking on overnight on-site call duties exceeding 24 hours and this problem had not been fully addressed by the reform programmes.

48. USFH said that HA's prime concerns in implementing the pilot doctor work reform programmes were patient safety and doctors' work-life balance. While the overall direction of reform was to reduce and share out the workload of doctors in public hospitals, it should be noted that the reform was not just an exercise to simply rationalise doctors' working hours. Regarding the issue of work hours, HA's target was to reduce all public hospital doctors' average weekly work hours to not exceeding 65 by the end of 2009 and their continuous work hours to a reasonable level in the long term.

49. Director (CS), HA supplemented that the long-term target of HA was to gradually reduce doctors' continuous working hours on weekdays as well as weekends and holidays to 16 and 24 hours respectively. In so doing, due regard must be paid to the manpower resources available and the work-shift arrangement for doctors and subject to ensuring the quality of service of public hospitals would not be affected. Although this target could not be achieved overnight, a number of reform initiatives had been put in place to relieve the workload of frontline doctors. For example, rest-breaks would be provided to doctors having to work for long hours. In addition, 91 Technical Services Assistants had been recruited to provide 24-hour blood-taking, electrocardiogram and intravenous cannulation services for patients in six acute hospitals with an aim to relieve the workload of frontline doctors and nurses.

50. Mr Albert CHAN noted from paragraph 9 of the Administration's paper that in 2009-2010, HA would deploy 23 additional Residents under specialist training to pressurised specialties and enhance the roles of experienced nurses to strengthen their support in patient management in selected acute hospitals. He considered that these measures could not resolve the root problem of heavy workload and long work hours of doctors and might compromise the quality of care to patients.

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51. USFH said that apart from the implementation of the pilot reform programmes as set out in paragraph 7 of the Administration's paper, additional Residents were deployed to certain pressurised specialties on a need basis where doctors consistently worked for long hours so as to relieve the heavy workload of frontline doctors. Director (CS), HA supplemented that in 2008-2009, HA had already allocated 47 newly recruited doctors to the six clinical specialties with prolonged work hour issues through the annual Resident Trainee/Resident Specialist allocation mechanism so as to manage the rising volume of public hospital services and relieve the serving pool of frontline doctors. This was proven effective in reducing doctors' work hours without compromising the quality of care and patient safety. Experienced nurses with proper clinical skills enhancement training could also help ease the workload of doctors and enhance multi-professional collaboration in the delivery of quality patient care.

52. Dr LEUNG Ka-lau was of the view that the crux of the problem was the absence of a formula in HA to project its manpower requirement for healthcare professionals based on the workload of public hospitals.

53. Director (CS), HA said that due to rapid advancement in medical technology and the continuous changing mode of operation, it was difficult for HA to adopt a formula for calculating its manpower requirement. Notwithstanding this, HA would work out from time to time its demand for new recruits of doctors per year over the next three years. In assessing the additional manpower needs, factors that would be taken into account included the effects of population ageing on HA's service demand, changes in medical technology, etc. Given that manpower resources could not be made available overnight, there was still a shortfall of doctors in public hospitals.

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54. At the request of Dr LEUNG Ka-lau, Director (CS), HA undertook to provide after the meeting information on the average number of medical and nursing staff on each night shift and the average weekly work hours of doctors at different ranks. Director (CS), HA added that according to a local survey on doctors' work hours conducted in September 2006, about 18% of all HA doctors worked for more than 65 hours in a week on average. Two surveys would be conducted in the first half and second half of 2009 respectively to ascertain whether there was any reduction in doctors' average weekly work hours after the implementation of the pilot doctor work reform programmes. In the meantime, the experience of the Kowloon West Cluster revealed that the number of its doctors working for more than 65 hours in a week on average had been reduced to around 5% after implementation of the pilot reform programmes.

55. In closing, the Chairman requested HA to report to the Panel the outcome of its final review on the pilot doctor work reform programmes after the Steering Committee on Doctor Work Hours submitted its final review report to the HA Board in early 2010. Mr CHAN Wai-yip suggested that the Panel should receive views from the relevant stakeholders when the subject was next discussed by the Panel.

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56. There being no other business, the meeting ended at 10:42 am.

Council Business Division 2
Legislative Council Secretariat
20 August 2009