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LC Paper No. CB(2)2439/08-09
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 13 July 2009, at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, SBS, JP (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon Fred LI Wah-ming, SBS, 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 Dr Hon PAN Pey-chyou
Member absent	:	Hon IP Kwok-him, GBS, JP
Public Officers attending	:	Item II Mr Patrick NIP, JP Deputy Secretary for Food and Health (Health) Miss Gloria LO Principal Assistant Secretary for Food and Health (Health) Dr Su Vui LO Director (Strategy & Planning) Hospital Authority Dr C T HUNG Cluster Chief Executive, Kowloon Central Cluster / Hospital Chief Executive, Queen Elizabeth Hospital Hospital Authority

Dr Tony KO
Chief Manager (Strategy, Service Planning & Knowledge Management)
Hospital Authority

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

Item III

Dr York CHOW, GBS, JP
Secretary for Food and Health

Ms Sandra LEE, JP
Permanent Secretary for Food and Health (Health)

Dr Thomas TSANG
Controller, Centre for Health Protection

Dr P Y LEUNG
Director (Quality & Safety)
Hospital Authority

Mr Anthony CHAN
Chief Pharmacist
Department of Health

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

Staff in attendance : Ms Maisie LAM
Senior Council Secretary (2)7

Ms Sandy HAU
Legislative Assistant (2)5

Action

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

There was no information paper issued since the last meeting.

Action

II. Reprovisioning of Yaumatei Specialist Clinic at Queen Elizabeth Hospital
(LC Paper No. CB(2)2133/08-09(01))

2. Deputy Secretary for Food and Health (Health) (DSFH(H)) briefed members on the Administration's proposal to reprovision Yaumatei Specialist Clinic (YMTSC) at a new Specialist Clinic Building at the Queen Elizabeth Hospital (QEH), details of which were set out in the Administration's paper.

3. Dr PAN Pey-chyou noted with concern that the places of the Geriatric Day Hospital and the Child Psychiatric Centre would be maintained at 45 and 25 respectively after the reprovisioning. He also noted that the Special Medical Care Centre (SMCC), which was currently located in the Ambulatory Care Centre (ACC) of QEH to provide comprehensive medical services to patients suffering from acquired immunodeficiency syndrome (AIDS), would be relocated to the new Specialist Clinic Building. However, the facilities of SMCC would remain the same after the relocation. Dr PAN asked whether the Administration would consider increasing the capacity of the above services to meet the growing demand.

4. DSFH(H) and Cluster Chief Executive, Kowloon Central Cluster, HA (CCE/KCC, HA) made the following response -

(a) the Hospital Authority (HA) had taken the opportunity of reprovisioning the services at YMTSC to QEH to strengthen and enhance the existing services, such as provision of more spacious environment for better quality of service to patients;

(b) the existing 45 places in the Geriatric Day Hospital would be maintained after the reprovisioning. Notwithstanding this, the support services for elderly patients in the community had been and would continuously be strengthened;

(c) additional funding had been and would be allocated to the Kowloon Central Cluster (KCC) in 2009-2010 and 2010-2011 to enhance the psychiatric services and to increase the number of child psychiatrists in the year ahead. In addition, co-operation scheme between the Child Psychiatric Centre and the Adolescent Medical Centre (AMC) of QEH, which presently provided medical consultation and psychological intervention for adolescents from 12 to 19 years of age and would be relocated to the new Specialist Clinic Building, would be rolled out; and

(d) additional resources had been allocated to KCC to enhance the services to patients suffering from AIDS.

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5. At the request of Dr PAN Pey-chyou, DSFH(H) undertook to provide the following information after the meeting -

Action

(a) the respective number of old and new cases and the average waiting time for first appointment of the Child Psychiatric Centre of YMTSC and AMC of QEH in each of the past five years;

(b) the number of child psychiatrists to be employed at the Child Psychiatric Centre in the year ahead; and

(c) the average waiting time for first appointment and the average length of stay of patients of the Geriatric Day Hospital of YMTSC in each of the past five years.

6. Dr LEUNG Ka-lau said that to his understanding, it was initially proposed that a medical centre of excellence be established at QEH. He requested the Administration to take into account the future development of QEH when considering the design of and the scope of services to be provided at the new Specialist Clinic Building.

7. DSFH(H) said that two respective Steering Committees had been set up to spearhead the projects of establishing multi-partite medical centres of excellence in the specialty areas of paediatrics and neuroscience. The Steering Committees were presently examining the relevant issues, such as the scope of services and the mode of operation, and no project sites had yet been identified.

8. Mr Vincent FANG expressed concern that the increase in the number of attendances in QEH after the repovisioning of YMTSC would aggravate the already very heavy people flow of QEH.

9. DSFH(H) responded that the new Specialist Clinic Building would be constructed at the site of the old Specialist Clinic Building at QEH and the area around it. There would be link bridges connecting the new Specialist Clinic Building to other clinical buildings. The relevant Government departments had also assessed the traffic volume of the district. Members of the public would have easy access to QEH.

10. CCE/KCC, HA supplemented that at present, the Ear, Nose and Throat Specialist Clinic recorded the highest number of attendance, i.e. 60 000 per year, amongst the various services provided at YMTSC. He assured members that HA had taken into account the people and traffic flow when deciding the reprovisioning site for YMTSC.

11. In response to Dr LEUNG Ka-lau's enquiry about the existing services being provided at the old Specialist Outpatient Clinic Building, DSFH(H) said that the Building was being used by the Baptist University to run a Chinese Medicine Clinic, which would be relocated to the Clinical Oncology Centre in QEH in due course.

12. In closing, the Chairman said that members of the Panel were in support of the proposed reprovisioning of YMTSC at QEH.

Action

III. Update on the prevention and control of Human Swine Influenza infection in Hong Kong
(LC Paper Nos. CB(2)2133/08-09(02) & (03) and CB(2)2170/08-09(01) & (02))

13. Secretary for Food and Health (SFH) provided an update on the latest situation of human swine influenza (HSI) epidemic and the Administration's strategy and measures to prevent and control the spread of the disease, and the key conditions of the tender for the procurement of HSI vaccine, details of which were set out in the Administration's papers (LC Paper Nos. CB(2)2133/08-09(02) and CB(2)2170/08-09(01)). SFH supplemented as follows -

(a) as of 12 July 2009, 135 countries/areas (including Hong Kong) in total had reported 95 132 confirmed cases, including 429 fatal cases, i.e. a fatality rate of 0.45%. In Hong Kong, there had been 1 265 confirmed cases of HSI. So far, 614 patients had been hospitalised and all except 15 had already been discharged. Amongst these 15 patients, 14 cases were in stable condition and one involving a Filipino woman was in critical condition since her admission to the Intensive Care Unit of the United Christian Hospital on 7 July 2009;

(b) HA's Designated Flu Clinics had provided treatment to a total of 8 949 patients with fever and influenza-like-illness (ILI). Amongst them, 161 patients were transferred to designated hospitals for further management. Patients with mild symptoms were provided with symptomatic treatment and Tamiflu was given to 2 016 ILI patients with chronic diseases or in immuno-compromised states;

(c) answers on whether the HSI virus would remain mild, or would become more virulent or severe, remained uncertain. It should however be noted that the number of fatal cases was increasing and Tamiflu-resistant HSI cases were recently detected. Hence, the procurement of HSI vaccines was necessary to safeguard public health against HSI; and

(d) as regards the tender conditions of the HSI vaccines, the contractual quantity was being drawn up with such flexibility that the Administration was at liberty to purchase three million doses first, and make subsequent orders up to six million doses if necessary to cover 1.5 to three million people. The order placed for seasonal influenza vaccines in both the private and public sectors was about 1.3 million in the past year.

Action

Key conditions of the tender for HSI vaccine

Estimated quantity

14. Ms Audrey EU expressed concern that many of the doses of the HSI vaccine would not be used even if the Administration only purchased three million doses, as the number of people receiving seasonal influenza vaccination each year was not high. Ms EU further asked whether the Administration had taken into account the factor of herd immunity when deciding the quantity to be procured. She said that to her understanding, it was more difficult for an infectious disease to spread in the community if 70% of the people in the at-risk group were immunised against the disease and obtained immunity. Dr LEUNG Ka-lau was of the view that the Administration should be more conservative in drawing up the minimum order for the HSI vaccines.

15. SFH said that some 300 000 people in eight target groups, which covered over 90% of residents living in residential care homes, received free seasonal influenza vaccination under the Government Influenza Vaccination Programme each year. According to information provided by the manufacturers, the private medical sector procured about one million of seasonal influenza each year. Given that vaccine manufacturers had recommended that two doses of HSI vaccine were required for each person, the minimum order of three million doses to cover 1.5 million at-risk people was on a par with that for the seasonal influenza vaccines. While the eventual take-up rate of the HSI vaccine would depend on various factors, it was expected that demand for the vaccine would be greater if more people got infected and came down with serious illness.

16. SFH further said that HSI vaccines were only available to governments so far. There was no alternative to Government procuring the vaccines in order to vaccinate the four at-risk target groups recommended by the Scientific Committees of the Centre for Health Protection (CHP), i.e. healthcare workers in both the public and private sectors, children aged six months or above and below six years old, elderly persons aged 65 and above, and persons at higher risk of death and complications from HSI due to pre-existing medical conditions. In the light of this, it was incumbent upon the Administration to secure adequate supply of HSI vaccines through this procurement process as production capacity was limited against a strong global demand.

17. Controller, Centre for Health Protection (Controller, CHP) supplemented that administering HSI vaccines for the four target groups, which had an estimated population of around two million, was not for herd immunity but for maintaining essential workforce to deliver healthcare services and protecting the more vulnerable groups in the population.

18. Ms Audrey EU noted that a clause would be included in the tender documents to the effect that any unused vaccines ordered and delivered could be returned to the manufacturer with refund. She asked whether it would be in the form of full or partial refund. Chief Pharmacist, Department of Health (Chief Pharmacist, DH) advised that it would be a full refund.

Action

Quality of the vaccine

19. Ms Audrey EU asked whether the Administration would consider including in the tender a clause to specify the date by which the tenderer had to obtain the regulatory approval by any of the authorities mentioned in paragraph 4(c) of the Administration's paper.

20. SFH said that the order would include safeguard clauses to require eventual approval of the vaccines from one of the specified overseas drug authorities. The vaccines would be deployed only after regulatory approval by an overseas authority and consequential local registration by the Department of Health (DH). To ensure timely delivery, a provision would be included in the tender documents to require the successful tenderer to deliver the vaccines to any public or private facility, medical institution or hospital in Hong Kong, to be designated by the Administration, on an "as and when required" basis within seven days from date of orders. Chief Pharmacist, DH supplemented that regulatory approval of the overseas drug authorities, most notably the Food and Drug Administration of the United States (US) and the European Medicines Agency of the European Union, was expected towards the end of 2009.

21. Mr Andrew CHENG noted that tenderers were not required to provide items (i), (ii), (iv) and (vi) outlined in paragraph 5(c) of the Administration's paper, which included regulatory approval of the vaccines by any of the specified overseas drug authorities, if they were yet available at the time of tender submission. Holding the view that these items were essential to prove the quality and safety of the vaccines, Mr CHENG expressed concern that the at-risk target groups would be left unprotected against HSI if the successful tenderer eventually was unable to fulfill these four conditions.

22. Chief Pharmacist, DH explained that given that there was a lead time of four to six months between placing the order and delivery and there were competing demands from various governments, the Administration had to proceed with the procurement process at this stage while regulatory approval of the HSI vaccines was still outstanding so that the vaccines were ready for use in the coming flu season. The Administration planned to award the tender in September/October 2009 after the close of the tender on 7 August 2009. As mentioned earlier at the meeting, regulatory approval of the overseas drug authorities was expected towards the end of 2009.

23. Mr Vincent FANG cited the recent news reports which stated that US would administer the HSI vaccines for the entire population in October 2009. He was concerned about whether the order of the Administration would be put on a long queue and the vaccines would only become commercially available several months after the vaccines had obtained regulatory approval by any one of the specified overseas drug authorities.

24. SFH responded that the Administration would only procure HSI vaccines which had obtained regulatory approval to ensure their safety, efficacy and quality. It was anticipated that manufacturers would be able to produce the first

Action

batch of vaccines around September 2009 and the relevant drug regulatory authorities could complete the approval processes in one to two months' time. Countries with local capability and capacity of manufacturing vaccines might be able to provide the vaccines for their population at an earlier time.

25. Mr Fred LI and Ms Audrey EU asked about the measures to be taken by the Administration if the successful tenderer could not obtain the regulatory approval of the specified drug authorities on or before the date as requested by the Administration. Chief Pharmacist, DH said that the Administration would follow up with the successful tenderer to see if this was due to a late submission of the results of the clinical tests.

Risk involved for HSI vaccines

26. Mr Albert CHAN sought information from the Administration on the possible side effects of people receiving HSI vaccines. Noting that the overall fatality rate from HSI was approximately 0.45%, Mr Albert HO asked about the assessment of the benefits of vaccination and potential risks of adverse vaccine effects for the target groups.

27. SFH said that in considering whether a defined population group was recommended to receive vaccination, the Scientific Committees had assessed the protective benefits of vaccination for the defined population group against potential side effects including rare ones like the Guillain-Barre Syndrome (GBS) which could cause paralysis and sometimes in permanent disability. Given that the elderly, young children and people with pre-existing medical conditions were more vulnerable and had a higher rate of complications and death arising from seasonal flu each year, the Scientific Committees were of the opinion that they were also at increased risk of medical complications, hospitalisation and death arising from HSI, and hence the benefits of HSI vaccination outweighted its risks in these groups. The Scientific Committee had also considered whether or not to recommend vaccinating the entire population against HSI. Their conclusion was that there was no such need because not all people were in the at-risk group and the balance between benefits of vaccination and potential risk of adverse vaccine effects was less clear for other groups of the population at this point in time.

28. SFH added that Hong Kong would closely monitor the development of the HSI virus in Europe, Korea, Japan and the Mainland in the northern hemisphere where winter flu season would arrive one to two months earlier than Hong Kong. It should be noted that the experience from Mexico, Argentina and Chile in the southern hemisphere suggested a high fatality rate from HSI with the arrival of the flu season in winter. The contractual quantity for the HSI vaccine was being drawn up with such flexibility that the Administration was at liberty to purchase any quantity within plus 20% or minus 40% of the five million doses the Administration planned to procure.

29. Controller, CHP supplemented that in drawing up the recommendations, the Scientific Committees had examined the worldwide epidemiology of HSI

Action

and took into account the adverse events caused by the seasonal influenza vaccines, as the HSI vaccines were being developed and had not been applied on a large scale so far. Overseas literature revealed that seasonal influenza vaccination might be associated with an excess incidence of GBS of one per one million among vaccines, whereas the overall fatality rate from HSI was about four per 1 000 and the specified target groups were at higher risk. Mr Albert HO and Mr Albert CHAN said that the Administration should make public the risk involved for HSI vaccination to enable the target groups to make an informed decision.

30. Ms Audrey EU asked whether the Administration would consider including a compensation clause in the tender for HSI vaccine to the effect that the Administration could claim compensation from the tenderer if there were any severe adverse events caused by the vaccine following vaccination.

31. Controller, CHP said that in line with the current practice adopted for other vaccines, no vaccine injury compensation programme was in place to cover the adverse events caused by the HSI vaccines. The HSI vaccination was a voluntary scheme and anyone who received vaccines would be informed about both the benefits and risks of vaccination. The Administration would seek legal advice from the Department of Justice if there were severe vaccine adverse events in the course of administering the HSI vaccination.

32. Mr Albert HO was of the view that a misadventure fund should be set up to provide compensations to people suffering from severe adverse side effects in order to avert the need for them to go through the very cumbersome legal proceedings, given the uncertainties associated with the HSI virus and the vaccines and that the vaccination for the four target groups was recommended and administered by the Administration. SFH said that the Administration would give further thought to this suggestion.

33. Mr Albert CHAN asked whether the Administration would consider specifying in the tender documents the maximum level of the vaccine-related risk that the vaccinees would be exposed to.

34. SFH responded that it was inappropriate to include such condition in the tender documents, as the new HSI vaccine being developed had not been applied on a large scale so far and the possible side effects of the vaccine were uncertain at this stage. Notwithstanding this, the tenderer was requested to submit at the time of tender submission a copy of the completed master formula, method of assay, finished product specifications, stability data with recommended self-storage condition of the vaccine; and if an adjuvant was contained in the vaccine, the amount was determined and shown to be within acceptable limits with respect to the expected amount. It was not unusual that the tenderers would include also in their tender submissions evidence that demonstrated their competitive advantages, such as a favourable report of the adverse vaccine events of the seasonal influenza vaccines they manufactured.

Action

Implementation of HSI vaccination

35. Ms Audrey EU asked about the implementation of HSI vaccination to the four target groups. Mr Fred LI expressed particular concern about how the Administration could ensure that all 886 000 elderly persons aged 65 and above would receive HSI vaccination, having regard to the fact that many elderly living in the community were not aware of the vaccination programme and were resistant to get vaccinated. Mr CHAN Hak-kan was concerned about the young children's take-up rate of the HSI vaccine, as many parents were advised by their family doctors that they should not let their children get vaccinated.

36. SFH said that it was the Administration's intention to brief the Panel on the implementation details of HSI and seasonal vaccinations in October 2009. The initial plan was to administer the seasonal flu vaccination for the elderly aged 65 and above before the arrival of the flu season in winter, i.e. around the end of October and early November 2009. The administration of the HSI vaccination to the target groups might take place at the end of December 2009 or January 2010, subject to the availability of HSI vaccines towards the end of 2009. In the meantime, the Administration would discuss with the private medical sector on their participation in the HSI vaccination programme, albeit the vaccination would principally be administered by public hospitals and clinics. SFH added that the Administration would step up publicity and public education closer to the time of the commencement of the vaccination programme, with a view to enhancing the awareness of the public and the private sector medical professionals of the latest development of the influenza pandemic, the uncertainties as to whether the severity of HSI would remain mild in winter and the scientific evidence on the potential risks of getting infected with HSI.

37. Mr Vincent FANG asked whether the HSI vaccines would be provided to private medical sector free of charge for their administration to the target groups. SFH responded in the positive, and said that the Administration's plan was to provide the participating doctors a subsidy of $50 per dose to cover the injection cost. The Administration would further discuss the arrangements with the private medical sector.

Adjustment of mitigation strategy

38. Dr LEUNG Ka-lau questioned the necessity of maintaining the response level to the highest level at "Emergency Response Level" under the Preparedness Plan for Pandemic Influenza in Hong Kong, having regard to the fact that HSI was so far manifesting itself in a relatively mild manner resembling seasonal flu. Noting that HA had also activated the "Emergency Response Level", Mr Vincent FANG enquired whether HA would lower its response level at the mitigation stage. They were concerned that this would result in the public and the medical personnel being less vigilant in fighting against HSI when the virus became more virulent or severe in future, as the response level could not be raised further.

Action

39. SFH said that the Administration had no plan to lower the response level at this stage, as the raising of the level of influenza pandemic alert to the highest phase 6 by the World Health Organization (WHO) on 11 June 2009 indicated that the criteria for a pandemic had been met and there was evidence confirming efficient human-to-human transmission of the virus. Although WHO presently characterised the influenza pandemic as moderate in severity, the severity of pandemics could change over time and it was necessary for the Administration to maintain vigilance on monitoring the development of this novel virus.

40. On the response level of HA, Director (Quality & Safety), HA said that HA's response system was formulated on the basis of the Administration's three-level response system. HA was obliged to follow the response level activated by the Administration to avoid creating policy inconsistency and causing confusion to the public. It should however be noted that the "Emergency Response Level" of HA was further classified into E1 and E2. At present, the Emergency Response Level (E2) was activated. To ensure early identification of severe cases and to reduce the risk of healthcare-associated infections, a comprehensive infection control infrastructure had been set up. Guideline for triage and management of patients with ILI seeking medical advice in the Designated Flu Clinics (DFCs) and the Accident and Emergency Departments had also been put in place. Director (Quality & Safety), HA further said that the related policies and guidelines for managing HSI in the mitigation phase would be fine-tuned in the light of the latest developments of HSI. For instance, flexible visiting arrangement had been adopted to allow husband to company his wife during labour.

41. Noting that the existing Preparedness Plan for Pandemic Influenza in Hong Kong was developed to face the challenge of avian flu, Dr LEUNG Ka-lau was of the view that in the long term, the Administration should formulate preparedness plans for different types of pandemic influenza.

42. Dr LEUNG Ka-lau asked the reason for requiring travellers to make health declaration at border control points during the mitigation stage. SFH responded that temperature screening and health declarations at the border control points would remain unchanged for the Administration to track the disease trend in the region. The Administration would also inform the health authorities in the neighbouring countries if a large number of transit passengers developed flu-like symptoms. Controller, CHP supplemented that the port health officers would take the travelers with severe symptoms and intercepted at the border control points to public hospitals for medical examination.

43. Dr LEUNG Ka-lau noted that section 4 of the Prevention and Control of Disease Regulation (Cap. 599A) required medical practitioners to notify the Director of Health if they had reason to suspect the existence of any of the infectious diseases specified in Schedule 1 to the Prevention and Control of Disease Ordinance (Cap. 599). He enquired as to whether private doctors were still required to report suspected HSI cases.

Action

44. Controller, CHP said that HSI was a statutorily notifiable disease under Cap. 599. However, the reporting criteria had been adjusted in the light of the latest situation of and knowledge gained about this novel virus in Hong Kong, especially the evidence so far that HSI caused relatively mild disease albeit transmitting easily through the population. Given that HSI had taken root in the community and the priority of the Administration was now put on detection of serious or fatal cases related to HSI, private doctors were required to report only those cases with severe confirmed HSI related illness. CHP had issued letters to private doctors informing them that patients with symptoms of influenza-like illness could be referred to the eight Designated Flu Clinics set up by HA for diagnosis and treatment. In addition, the Public Health Laboratory Centre of DH would provide laboratory support for patients with severe illnesses i.e. in intensive care unit/requiring ventilation support, suspected to be due to HSI, so as to facilitate reporting of these cases.

45. Dr LEUNG asked whether the Administration would consider removing HSI from the list of infectious diseases statutorily notifiable by medical practitioners if suspected cases were not required to be reported. Controller, CHP responded that the Administration would keep HSI as a statutorily notifiable disease for the time being, as the listing empowered the Administration to implement various disease control measures and surveillance activities.

Arrangement for commencement of the new school year

46. Mr CHAN Hak-kan noted that some kindergartens planned to commence classes in the new school year in August 2009. He urged the Administration to make early announcement as to whether schools could commence classes as scheduled. SFH said that 20-30% of the private independent kindergartens would commence classes in August each year. The Administration would announce the arrangements one to two weeks ahead of the commencement of the new school year to facilitate the preparation of schools.

Conclusion

47. In closing, the Chairman requested the Administration to take into account the views and concerns of members on the quality and safety of the HSI vaccines during the procurement process.

IV. Any other business

48. Mr Albert HO said that at the meeting of the Panel on Welfare Services held on 11 July 2009, members had suggested that a joint meeting with the Panel on Health Services should be held to receive views from deputations and to discuss with the Administration the issue of medical and social rehabilitation services for ex-mentally ill persons.

49. Mr Albert CHAN said that he had previously discussed the matter with the Chairman in his capacity as the Chairman of the Panel on Welfare Services,

Action

and was given to understand that the Working Group on Mental Health Services set up by the Food and Health Bureau was reviewing the existing mental health services and would come up with the way forward in September 2009.

50. The Chairman sought members' view on holding a joint meeting with the Panel on Welfare Services to discuss the issue. Members agreed.

(*Post-meeting note*: A joint meeting of the Panel and Panel on Welfare Services has been scheduled for 30 September 2009 at 9:00 am to meet with deputations and the Administration.)

51. There being no other business, the meeting ended at 10:35 am.

Council Business Division 2
Legislative Council Secretariat
3 September 2009