立法會
Legislative Council

LC Paper No. CB(2)1014/09-10
Ref : CB2/PL/HS (These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 8 February 2010, 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 CHEUNG Man-kwong Hon Andrew CHENG Kar-foo Hon Audrey EU Yuet-mee, SC, JP Hon CHAN Hak-kan Hon CHAN Kin-por, JP Hon CHEUNG Kwok-che Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou
Members absent	:	Hon Fred LI Wah-ming, SBS, JP Hon Cyd HO Sau-lan
Public Officers attending	:	Items IV to VI Professor Gabriel M LEUNG, JP Under Secretary for Food and Health Items IV & V Dr W L CHEUNG Director (Cluster Services) Hospital Authority Item IV only Miss Theresa YU Assistant Secretary for Food and Health (Health) 7

		Dr Regina CHING, JP Assistant Director of Health (Health Promotion)
		Ms TONG Yuen-fan Transplant Coordinator, Prince of Wales Hospital Hospital Authority
		<u>Item V only</u>
		Miss Gloria LO Principal Assistant Secretary for Food and Health (Health) 2
		Dr LIU Hing-wing Chief Manager (Clinical Effectiveness & Technology Management) Hospital Authority
		Mr Raymond WONG Chief Manager (Business Support Services) Hospital Authority
		Ms Irene HO Project Manager (Capital Block Vote) Hospital Authority
		<u>Item VI only</u>
		Dr CHUANG Shuk-kwan Consultant Community Medicine (Communicable Disease) Surveillance and Epidemiology Branch Centre for Health Protection
		Dr CHAN Man-chung Chairman of the Expert Group on Serious Adverse Events following HSI vaccination
Clerk in attendance	**:**	Miss Mary SO Chief Council Secretary (2) 5
Staff in attendance	**:**	Ms Maisie LAM Senior Council Secretary (2) 6
		Ms Sandy HAU Legislative Assistant (2) 5

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I. Confirmation of minutes
(LC Paper No. CB(2)864/09-10)

The minutes of the meeting held on 11 January 2010 were confirmed.

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

2. There was no information paper issued since the last meeting.

III. Discussion items for the next meeting
(LC Paper Nos. CB(2)865/09-10(01) and (02))

3. Members agreed to discuss the issue of "Human Organ Transplant (Appeal) Regulations" proposed by the Administration at the next regular meeting scheduled for 8 March 2010.

4. Ms Audrey EU proposed to discuss the issue of human swine influenza (HSI) vaccination programme at the next regular meeting. The Chairman said that as the Panel would discuss HSI vaccine for pregnant women under agenda item VI below, members could consider whether further discussion on HSI vaccination programme was required after the discussion.

(*Post-meeting note*: At the request of the Administration and with the concurrence of the Chairman, the item "Healthcare service reform - Shared care projects" was added to the agenda of the March meeting.)

IV. Organ donation campaign
(LC Paper Nos. CB(2)865/09-10(03) and (04))

5. Under Secretary for Food and Health (USFH) briefed members on the progress of the campaign to promote organ donation, details of which were set out in the Administration's paper (LC Paper No. CB(2)865/09-10(03)).

6. Mr CHAN Kin-por noted from paragraph 4 of the Administration's paper that among the families of the deceased approached by the Transplant Coordinators of the Hospital Authority (HA) in 2009, about half still refused to donate the organs of the deceased. He enquired about the number of refusal cases whereby the deceased had recorded his/her wish to donate organs after death by registering on the Centralised Organ Donation Register (CODR) or signing the organ donation card. Ms Audrey EU, Mr Andrew CHENG and Dr PAN Pey-chyou raised a similar question.

7. Director (Cluster Services), HA (Director(CS), HA) responded that when a prospective donor passed away, medical personnel would make an assessment of each case to verify the deceased's wish and feasibility of organ donation. For cases

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where the deceased had recorded his/her wish to donate organs after death, more than 90% of their family members agreed to the donation. The major reason for the shortage of organs for transplant was that many people had not recorded their wishes about donation or discussed it with their families. Transplant Coordinator, Prince of Wales Hospital, HA supplemented that in her some 11 years' experience as a Transplant Coordinator, she had only come across two cases whereby the families refused to the donation of organs of the deceased who had signed the organ donation card.

8. Mr CHAN Kin-por considered that one of the reasons why some people were hesitant in registering their wish to donate organs after death was because they feared that medical workers would not endeavour to save them when they were in critical condition. USFH responded that human would only be removed for transplantation following the certification of brain death and with the consent of his/her family.

9. Ms Audrey EU asked about the reason for not requiring the prospective donors to indicate, at the time of registration with CODR, the persons to whom they had made their donation wish known. Dr PAN Pey-chyou raised a similar question.

10. Assistant Director of Health (Health Promotion) (ADH(HP)) responded that the Administration had given thought to collecting information of the persons to whom the prospective donors had made known their donation wish when establishing the CODR. However, to do so would not satisfy the requirement of the Privacy Impact Assessment commissioned to safeguard protection of personal data collected for the purpose of establishing the CODR.

11. Ms Audrey EU said that to better promote organ donation, consideration should be given to posting the list of registrants for organ donation, in particular those who were community leaders, on the organ donation website of the Department of Health (DH).

12. USFH responded that all collected data in CODR were classified as personal and treated with strict confidentiality for exclusive access by authorised personnel. Nevertheless, registrants were welcomed to inform others of their wish to donate organs after death. The Chief Executive, Chief Secretary for Administration, Financial Secretary, Secretary for Justice and Secretary for Food and Health had openly indicated that they had signed the organ donation cards and also registered with CODR. Ms EU suggested that the Administration could seek the view of the registrants on whether they were willing to have their identity be disclosed for promotional purpose at the time of registration.

13. Mr Andrew CHENG said that despite the roll-out of the organ donation promotional activities set out in paragraph 8 of the Administration's paper, the concept of organ donation was still not widely accepted by the general public. He urged the Administration to step up its publicity efforts to promote the culture of organ donation. Mr CHENG further said that consideration could be given to

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enabling the registrants on CODR to leave a personal message to their families about their wish to donate organs after death, given the importance of family's acceptance. This could help the families to make the decision on organ donation when they were still suffering from the loss of their loved ones.

14. USFH took note of Mr CHENG's suggestions. He agreed that in cases where the deceased had made known their wish to donate organs, the family members would usually respect their wish. A survey conducted by DH in 2007 revealed that amongst the respondents who originally indicated their unwillingness to donate the organs of their deceased family members, more than 70% indicated that they would change their mind if they knew the deceased's wish about donation.

15. Dr PAN Pey-chyou suggested that the Administration should make use of popular websites to promote organ donation, say, posting heart-warming cases of how the recipients benefited from transplantation to sustain their lives.

16. ADH(HP) responded that the Administration had promulgated the message of organ donation through pop-up advertisements on yahoo.com in August 2009. It was found that there had been an increasing number of registrations on CODR during this period. The Administration would continue to make use of popular electronic media, such as popular websites, facebook and twitter, to promote organ donation in a more extensive and comprehensive manner.

17. Mr CHAN Kin-por noted from the organ donation promotional leaflet that every day, there were more than 2 000 patients in Hong Kong having an imminent need for organ or tissue transplant. He asked whether this represented the total number of patients on the transplant waiting list. USFH replied in the positive.

18. Ms Audrey EU asked whether the Administration had set a target on the number of registrants for organ donation in order to meet the demand of patients in need of organ transplant.

19. USFH responded that it would be difficult for the Administration to set a target on the number of registrants for organ donation because information such as when the organs of the registrants would become available and whether they were suitable for the recipients in terms of size, blood type, etc. was unpredictable. USFH however pointed out that as at 8 January 2010, there had been about 40 000 new registrants on CODR since its launch on 24 November 2008 and about 5 000 registrants on the Hong Kong Medical Association's Organ Donation Register had agreed to transfer their data to CODR. DH and HA would, in collaboration with the relevant healthcare professional bodies and non-governmental organisations, continue to promote organ donation to attract more people to donate organs after death and agreed to the donation of organs of their deceased family members.

20. Dr LEUNG Ka-lau considered it inconceivably low that both the number of heart transplantation in public hospitals in 2009 and the number of patients waiting for heart transplant as at 31 December 2009 was only ten, having regard to the fact

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that heart disease was the second killer disease in Hong Kong. Dr LEUNG asked whether this was due to the lack of resources for carrying out heart transplantation.

21. USFH responded that the reason why the number of heart transplantation was small was due to the fact that the blood type and the size of the heart of the donors and the potential receipts needed to be matched. Moreover, the heart of the donors had to be in good condition to minimise the risk of complications or side effects after the transplantation. On the reason why the number of patients waiting for heart transplant was small, USFH pointed out that among the different types of heart disease, coronary heart disease was the commonest but heart transplantation was not a viable treatment option for patients suffering from this disease.

22. In response to Dr LEUNG's further enquiry about the criteria for listing a patient for heart transplantation, Director(CS), HA said that factors that would be taken into account included the type of the heart disease the patient was suffering and the level of operative risk that the patient could stand.

23. In closing, the Chairman said that the Administration should take into account members' suggestions in encouraging prospective donors to register their wish to donate organs on CODR and make known their wish to their families.

V. Modernization of medical equipments in the Hospital Authority
(LC Paper No. CB(2)865/09-10(05))

24. USFH and Director(CS), HA briefed members on the modernisation of medical equipment in HA to improve the quality and effectiveness of HA's services, details of which were set out in the Administration's paper.

25. Dr LEUNG Ka-lau pointed out that while Positron Emission Tomography (PET) was an effective and commonly-used method for cancer diagnosis, HA had so far procured only one PET scanner for use in the Queen Elizabeth Hospital (QEH). In addition, unlike other diagnostic imaging services, the use of this scanner was not covered by the standard fees and charges of public hospitals and users would be charged at about $10,000. He asked HA whether there was any plan to add more PET scanners and scrap the charging policy for the benefit of patients.

26. Director(CS), HA responded that the introduction of the PET scanner for use in QEH was on a pilot basis to assess the cost-effectiveness of PET applications, as the technology was relatively new at that time. Hence, patients had to pay at their own expenses on using the scanner, but partial or full subsidy would be provided to needy patients, depending on their financial situation. Director(CS), HA further said that apart from PET, there were also other diagnosis imaging services, such as Magnetic Resonance Imaging and Computerised Tomography (CT), available at public hospitals for diagnosis of cancer. Nevertheless, he agreed that there was a need to review the cost-effectiveness of PET and the current charging policy in the light of the service demand and the development of this technology. Dr LEUNG

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sought clarification on whether PET was the only type of diagnosis imaging service not being covered by standard fees and charges, Director(CS), HA replied in the positive.

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27. Mr CHEUNG Kwok-che requested HA to provide information in writing on the reason for setting the charge for a PET scan at about $10,000; the number of patients using the PET scanning service in 2009, together with a breakdown by whether or not they were provided with subsidy to cover the charge on using the scanner; and the prevailing market rate for a PET scan in the private sector.

28. Mr CHEUNG Man-kwong noted that with the additional funding support from the Government, HA had allocated around $1,280 million from 2007/2008 to 2009/2010 to carry out a major exercise for replacement and procurement of medical equipment. He was concerned about whether the allocation of the medical equipment purchased in the exercise was mainly concentrated in large regional hospitals. Mr CHAN Hak-kan and Mr Albert HO also expressed concern about whether there was an uneven distribution of medical equipment amongst hospitals. Mr CHEUNG further said that when examining the Estimates of Expenditure for 2009-2010 at the special meeting of the Finance Committee on 25 March 2009, he had urged the Administration to attend to the equipment need of small district hospitals and provide the Our Lady of Maryknoll Hospital (OLMH) with a CT scanner as soon as possible, as patients of OLMH were required to attend CT scanning in the Kwong Wah Hospital and the average waiting time was about one year. He enquired HA whether a CT scanner had been acquired for OLMH.

29. USFH and Director(CS), HA responded as follows -

(a) the services of HA were delivered on a cluster basis, with each of its seven hospital clusters comprising a well-balanced mix of acute and convalescence/rehabilitation hospitals to provide a full range of health care services. The clustering arrangement enabled clear delineation of roles of different hospitals within each cluster and delivery of health care services in a cost effective manner. It also minimised duplication of services and allowed collaboration and complementary support amongst hospitals. On the other hand, to ensure cost-effectiveness and the quality of care, some specialist services with a relatively small demand and requiring complex supporting facilities for delivery were mainly provided on a cross-cluster basis under a service network formed by two or more clusters. A cross-cluster referral mechanism was in place in HA for referral of patients in need to hospitals in other clusters for appropriate follow-up treatment;

(b) any replacement or addition of medical equipment would be made on a need basis rather than for the purpose of spreading out the distribution of equipment among hospitals, as the role of each hospital was different under the cluster arrangement. In mapping out the procurement plan, HA would take into account the technology level

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and age profile of all existing equipment, the self-assessment of each cluster on its equipment need and the recommendations of the expert committee. There was no cause for concern that district hospitals would not be provided with appropriate medical equipment to provide quality services to patients; and

(c) HA was in the process of procuring a CT scanner for OLMH. It was expected that the waiting time of OLMH patients for CT scanning could be shortened after the installation of the equipment.

30. Mr CHEUNG Man-kwong expressed dissatisfaction that the Administration's paper did not give sufficient information on the number of the various types of medical equipment procured in the replacement and procurement exercise referred to in paragraph 29 above and their distribution amongst hospitals. He said that a brief summary of the types of medical equipment purchased and the cost involved as shown in the Annex of the Administration's paper could not facilitate members' consideration as to whether each hospital was provided with proper and adequate medical equipment for delivery of quality healthcare services. Mr Albert HO and Mr CHEUNG Kwok-che expressed similar concern. Mr CHEUNG Man-kwong requested HA to provide the following information after the meeting -

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(a) the number of the various types of medical equipment procured in the replacement and procurement exercise and their distribution amongst hospitals; and

(b) a list setting out the basic medical equipment that each type of hospital should be provided with and whether these equipment were currently available in the hospitals concerned and, if not, the procurement plan of HA.

31. Referring to the cross-cluster referral mechanism mentioned in paragraph 30(a) above, Dr PAN Pey-chyou said that to his understanding, patients being referred to other clusters for treatment were subject to a longer waiting time than non-referral cases. He urged HA to look into the matter to ensure fair access to treatment.

32. Director(CS), HA assured members that patients would be arranged to receive treatment according to their conditions, irrespective of whether they were referred from other clusters. He said that Dr PAN could provide after the meeting details of the cases he referred to for him to follow-up. Dr PAN requested Director(CS), HA to further provide information on the waiting time for various types of oncology diagnosis and treatment in each cluster, with a breakdown by patients who were referred from other clusters for treatment and patients who received care in clusters in their own residential districts, as well as the number of patients who died while waiting for diagnosis or treatment.

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33. Mr CHAN Hak-kan noted from the Annex of the Administration's paper that amongst the various types of medical equipment purchased by HA with additional

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funding from the Government from 2007-2008 and 2009-2010, radiological and radiotherapy equipment was the largest and the second largest expenditure item respectively. He queried about the distribution of these equipment among clusters. Mr Albert HO raised a similar question. He further said that HA should not rely on patients to seek treatment from other clusters, as convenience to patients was of paramount importance.

34. Director(CS), HA responded that HA had acquired 14 Linear Accelerators equipped with new technologies in the past three years and would continue to buy additional Linear Accelerators in the coming year. The existing Linear Accelerators were installed at the six cancer centres in the territory and their distribution was as follows: five for the Hong Kong East and Hong Kong West Clusters; seven for the Kowloon Central Cluster which provided radiation treatment for cancer patients of both the Kowloon Central and Kowloon East Clusters; four for the Kowloon West Cluster; five for the New Territories East Cluster; and four for the New Territories West Cluster. To meet the demand of cancer patients for radiotherapy treatment, which at present recorded a 2% increase each year, HA was exploring the establishment of a new cancer centre in the Kowloon East Cluster upon redevelopment of the United Christian Hospital.

35. In response to Mr Albert HO's enquiry about whether private patients would be given priority over other patients in the use of medical equipment, USFH replied in the negative, and stressed that the access of any services in public hospitals would be based on clinician's professional judgement on the conditions of patients.

36. Mr CHAN Hak-kan enquired whether, apart from clinical equipment, HA had acquired any information technology equipment with a view to enhancing file management and reducing dispensing errors.

37. USFH responded that the implementation of the Filmless HA project across all clusters in the next four years starting from 2010-2011 was one of the priority areas of HA for further modernisation of its equipment. The project was a HA-wide initiative to enable capturing, archiving and distributing radiology images in digital formats through electronic network and new generations of X-ray machines. By going filmless in HA, X-ray and other images could be efficiently transmitted in digital format among all HA hospitals/clinics to facilitate diagnosis and treatment of patients, hence avoiding delay due to retrieval of films or loss of films. In addition, clinicians could adjust the contrast of digital images easily to avoid unnecessary re-examination and irradiation to patients. The project would also contribute to the Government's initiative of developing a territory-wide electronic Health Record system.

38. On the prevention of dispensing errors, Director(CS), HA said that a task force had been set up in HA to study, among others, the application of barcode technology to enhance HA's drug procurement and dispensing system.

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39. Mr Andrew CHENG noted with concern from paragraph four of the Administration's paper that major equipment (with unit cost exceeding $1 million) that aged more than ten years still accounted for 36% of the major equipment of HA following the replacement and procurement exercise from 2007-2008 to 2009-2010. He was of the view that the life expectancy of major medial equipment should be shortened from more than ten years to, say, eight or five years, depending on their frequency of usage.

40. USFH responded that HA would closely monitor the utilisation of medical equipment and service demand to ensure that proper and adequate medical equipment were available for delivery of quality healthcare. As regards the life expectancy of major medial equipment, reference would be made to the practices of the medical sector of other countries, such as Australia, the United Kingdom, the United States and Canada.

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41. At the request of Mr CHENG, Director(CS), HA undertook to provide information in writing on the conditions of the major equipment which aged more than ten years, with a breakdown by the equipment type and cluster, and the detailed replacement plan of these aged equipment.

42. In closing, the Chairman requested the Administration to provide the information referred to in paragraphs 27, 30, 32 and 41 above.

VI. Human swine influenza vaccine for pregnant women

43. USFH reported that the Expert Group on Serious Adverse Events with History of Human Swine Influenza (the Expert Group) had met on 28 January 2010 to discuss the two cases of intrauterine deaths (IUD) with history of HSI vaccination which was reported to DH on 20 and 23 January 2010 respectively. The Expert Group noted that both cases had known risk factors, namely, advanced maternal age and long-term medication in one case and gestational diabetes mellitus in the other. It also noted that more extensive overseas experience and recommendations from the World Health Organization (WHO) on the use of HSI vaccine in pregnant women had confirmed the safety profile of HSI vaccine including the lack of any demonstrable association with IUD. There was currently no evidence that HSI vaccines increased the chance of IUD based on both local data and international experience. The Expert Group concluded that it was unlikely that the two observed IUD cases were caused by previous HSI vaccination. USFH further said that the Administration would continue to closely monitor the development of the pandemic and the implementation of the HSI vaccination programme to safeguard public health. The Centre for Health Protection (CHP) of DH would also monitor serious adverse events with history of HSI vaccination through its surveillance system.

44. Ms Audrey EU said that when the Administration sought the Legislative Council's support for a new commitment of $700 million for procurement of HSI

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vaccine and the related injection in June 2009, she was given to understand that the Administration's intention was to have the target groups received the vaccines by April 2010 as timely vaccination before the arrival of the peak season could protect them from complications of HSI. She enquired about the cumulative total of HSI jabs administered so far and the average number of jabs administered each day. She further asked how the Administration could prevent the three million doses of HSI vaccines purchased from going to waste. Mr CHAN Hak-kan raised a similar question. Mr CHEUNG Kwok-che asked whether consideration could be given to expand the vaccination programme to include people not belonging to the target groups.

45. USFH responded as follows -

(a) the cumulative total of HSI jabs administered since the start of the vaccination programme on 21 December 2009 was around 160 000. On average, some 3 000 doses of HSI vaccine were administered each day; and

(b) traditionally, seasonal influenza in Hong Kong was more prevalent in January to March and July to August. It should however be noted that Hong Kong had yet entered the winter influenza peak season this year. It was also uncertain at this point in time when the coming winter and summer influenza peak would arrive and whether the HSI virus would remain mild or become more severe. Hence, the Administration would remain prudent in implementing the HSI vaccination programme. At present, it had no plan to extend the programme to include people not belonging to the target groups and no deadline had ever been set for the target groups to receive the HSI vaccines.

46. Ms EU expressed dissatisfaction that USFH's reply did not address her concern on how to prevent the HSI vaccines purchased from going to waste. She requested the Administration to provide information on the expected doses of vaccines that would remain unused by April 2010 after the meeting.

47. Mr CHAN Hak-kan expressed concern that the reported cases of IUD with history of HSI vaccination would aggravate pregnant women's already low take-up rate of the vaccine. He urged the Administration to step up publicity to facilitate pregnant women to be aware of the benefits of vaccination and that no causal relationship had been found between HSI vaccination and IUD.

48. USFH advised that as at 31 January 2010, 359 pregnant women in Hong Kong had been confirmed with HSI. Among them, 204 had been hospitalised, which represented a hospitalisation rate of 57%. It was more than four times higher than the corresponding rate of female HSI patients of the same age group, which stood at about 12%. Since pregnant women were at increased risk of complications and hospitalisation arising from HSI, the benefits of HSI vaccination outweighed its potential risks of adverse vaccine effects in pregnant women. Moreover, over

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100 million people worldwide had received HSI vaccination to date and there was currently no evidence that HSI vaccines increased the chance of IUD based on both local data and international experience. That said, pregnant women had to make their own decision as the vaccination was voluntary.

49. Chairman of the Expert Group supplemented that the existing problem was that the attention of the members of the public had been focused on the single cases of suspected adverse HSI vaccine effects and the scientific information on the benefits of vaccination had been overlooked. He pointed out that as at 8 February 2010, the number of fatal and severe cases of HSI in Hong Kong was 66 and about 250 respectively. In response to Ms Audrey EU's enquiry on whether any of the fatal cases had received HSI vaccination, USFH replied in the negative.

50. Mr Andrew CHENG considered that, to rebuild pregnant women's confidence in HSI vaccination and ease their concern about the potential risks of adverse vaccine effects, the Administration should strengthen promotion of the benefits of vaccination in public hospitals and clinics. At present, pregnant women were being given varying advice from private doctors on whether to receive vaccination. USFH responded that information on the details of the HSI vaccination programme were made available at DH's Maternal and Child Health Centres.

51. Mr IP Kwok-him was of the view that the current unawareness of the members of the public on the risk arising from HSI infection was attributed by the lack of publicity by the Administration. He urged the Administration to step up efforts in this regard to facilitate pregnant women to make an informed decision on vaccination.

52. USFH responded that HA had been announcing fatal cases of HSI and releasing weekly statistics of the number of patients attended the Designated Flu Clinics and conditions of the confirmed HSI patients. The information had also been uploaded onto CHP's website.

53. Mr CHEUNG Kwok-che noted from the statement issued by the Expert Group on 28 January 2010 on the two reported cases of IUD with history of HSI vaccination that about 150 to 220 cases of IUD occurred in Hong Kong every year. He asked the reason why a significant proportion, i.e. 15 to 70%, of the cases did not have identifiable causes.

54. USFH responded that while an autopsy might diagnose the causes of IUD, many parents would decline to do so at the desperate moment. It should also be noted that some autopsy cases of stillbirth were classified as idiopathic as no identifiable cause could be established after investigations on whether the stillbirth was caused by infection, genetic or metabolic disorders. USFH further said that as at 27 January 2010, a total of 1 375 pregnant women in Hong Kong had received HSI vaccine. Currently, the proportion of IUD among vaccination women had not exceeded the local baseline incidence of IUD, i.e. around 0.15% versus 0.2 to 0.4%. The rate of stillbirths among vaccinated pregnant women was therefore at the low end of usual background levels.

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55. Dr LEUNG Ka-lau held the view that only those vaccinated women whose pregnancy had lasted 24 weeks or longer should be included in the denominator for calculating the proportion of IUD among vaccinated women, given that stillbirth was the death of a fetus in the uterus after 24th week of pregnancy.

56. Consultant Community Medicine (Communicable Disease), CHP advised that the Administration did not have information on the weeks of gestation of the pregnant women receiving vaccination. Taking into account the factor that the possibility of miscarriage before the 24th week of pregnancy was about 20%, the denominator for calculating the rate of stillbirths among vaccinated pregnant women was therefore the total number of vaccinated pregnant women multiplied by 80%. Such calculation enabled a like-with-like comparison with the local baseline incidence of IUD, of which the denominator was the total number of deliveries (including live births and stillbirths).

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57. In closing, the Chairman requested the Administration to provide the up-to-date statistics on the cumulative total of HSI jabs administered, the average number of jabs administered each day, as well as the expected doses of vaccines that would remain unused by April 2010.

58. There being no other business, the meeting ended at 10:45 am.

Council Business Division 2
Legislative Council Secretariat
5 March 2010