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Report of the Panel on Health Services
for submission to the Legislative Council

Purpose

This report gives an account of the work of the Panel on Health Services ("the Panel") during the 2022 session of the Legislative Council ("LegCo"). It will be tabled at the Council meeting of 7 December 2022 in accordance with Rule 77(14) of the Rules of Procedure of LegCo.

The Panel

2. The Panel was formed by resolution of LegCo on 8 July 1998, as amended on 20 December 2000, 9 October 2002, 11 July 2007, 2 July 2008 and 26 October 2022 for the purpose of monitoring and examining Government policies and issues of public concern relating to medical and health services. The terms of reference of the Panel are in **Appendix 1**.

3. The Panel comprises 19 members, with Hon Tommy CHEUNG Yu-yan and Hon CHAN Hoi-yan elected as Chairman and Deputy Chairman respectively. The membership list of the Panel is in **Appendix 2**.

Major work

Prevention and control of coronavirus disease 2019 in Hong Kong

4. Since the outbreak of the fifth wave of coronavirus disease 2019 ("COVID-19") epidemic in late December 2021, the Panel has been actively monitoring the measures taken by the Administration to prevent and control COVID-19. Following the election of the Chairman and Deputy Chairman of the Panel in January 2022, the Panel received the Administration's briefings on the above measures and discussed the measures at the subsequent regular monthly meetings. The Panel will

continue to receive a briefing and discuss such measures at its meeting on 9 December 2022.

Immigration control measures

5. Some members expressed concerns about the impact of the route-specific flight suspension mechanism on the tourism industry and passengers. In light of members' concern, the Government subsequently suspended the route-specific flight mechanism starting from 7 July 2022. While a number of members supported the Administration's decision, some members expressed concerns about a possible increase in the number of inbound passengers and hence the demand for the rooms of designated quarantine hotels. Some members suggested that the quarantine period of inbound persons should be adjusted. After considering the proposal, the Administration gradually relaxed the quarantine requirements. Firstly, starting from 12 August 2022, inbound persons from overseas places or Taiwan were subject to quarantine under the "3+4" model (i.e. compulsory quarantine in designated quarantine hotels for three days, followed by medical surveillance at home for four days). Subsequently starting from 26 September 2022, the quarantine arrangements were adjusted from the model of "3+4" to "0+3" (i.e. no compulsory quarantine with only three days of medical surveillance).

6. Noting that inbound persons were subject to the Amber Code restrictions of the Vaccine Pass during medical surveillance under the "0+3" arrangements, some members expressed concerns about whether the Administration would consider relaxing the restrictions by allowing persons with negative nucleic acid test results to enter catering premises. Some other members urged the Administration to consider reducing the frequency of testing required of travellers and allowing travel agencies to adopt the travel mode of "arriving and leaving in a group", so that inbound tour group travellers with the Amber Code could also be allowed to enter designated tourist attractions and dine at designated catering premises. Besides, some members requested the Administration to implement the "0+0" arrangements (i.e. lifting the medical surveillance requirement for inbound persons). The Administration advised that it was necessary to review more data and consider the operation of the entire public healthcare system before deciding whether the arrangements for inbound persons could be further adjusted. Subsequently, the Administration announced that specific arrangements for inbound tour group travellers would be launched in November 2022, under which travellers would be allowed to adopt the aforesaid travel mode of "arriving and leaving in a group" if their itineraries were pre-registered. The number of nucleic acid tests undergone by inbound persons from overseas places or Taiwan was also reduced from four to two.

Assisting Hong Kong citizens in visiting the Mainland

7. Some members suggested that the Administration should implement "reverse quarantine" (or "pre-departure quarantine"), i.e. allowing Hong Kong citizens travelling to the Mainland to undergo quarantine in Hong Kong, so that they could be exempted from the quarantine requirements of the Mainland. They also considered that priority should be given to cross-border workers and students, and citizens with medical needs if such quarantine arrangement was implemented.

8. Some members also expressed concerns that the Shenzhen authorities would reduce the quota for Shenzhen quarantine hotels. They also considered that the Administration should take the initiative to communicate with the Mainland authorities, and publish such information on the Government's website so that the public would understand the rationale for changes in the Mainland's policy. Some other members raised concern about the difference in testing standards between Hong Kong and the Mainland. This had posed hindrance to some people when they crossed the border to the Mainland because of failing to meet the Mainland requirements on Ct values. They asked the Administration to discuss the matter on unifying the rehabilitation standards of the two places with the Mainland authorities.

Testing measures

9. Some members expressed concerns about the testing arrangements in Hong Kong, in particular that only about 95% of the test results could be issued to members of the public within 24 hours. Given that testing arrangements in the Mainland were convenient and efficient, they urged the Administration to enhance the local testing arrangements by making reference to the practice in the Mainland. A question was also raised as to whether a confirmed patient could be discharged early from isolation and his or her close contacts also discharged early from quarantine if the confirmed patient had obtained negative rapid antigen test ("RAT") results for two successive days before Day 6 and Day 7.

10. The Administration advised that it would conduct COVID-19 testing according to priority in a tiered manner, with a target of issuing 100% of the test results within 24 hours. However, for the relatively urgent cases, such as those in hospitals and residential care homes or suspected cases, the Administration would request the contractors to issue results within six hours. Besides, under the test-and-hold arrangement at the Shenzhen Bay Control Point, most of the test results would be issued within 90 minutes. The Administration pointed out that around 70% of the population could reach community testing centres or community testing

stations within 15 minutes of walking at most. Currently, members of the public undergoing testing were required to fill in registration information beforehand to simplify the registration process and enhance the efficiency of testing. At present, most inbound travellers could complete the testing at the airport within 15 minutes. Members of the public might complete their isolation early after obtaining negative results of RAT taken on their own on both Day 6 and Day 7. Close contacts were at risk of infection as a result of living with infected persons. As assessed by the Administration, the infection period was within seven days.

Measures to prevent the spreading of the virus

11. Some members expressed concerns about whether the Administration would consider subsidizing residential care homes for the elderly ("RCHEs") to install an air purifier for each bed to reduce the risk of virus transmission. The Administration advised that RCHEs were the focus of the Government's virus prevention and control work. With the increase in the number of vaccinated elders in RCHEs, the hospitalization rate of confirmed cases among them had dropped significantly. To reduce the risk of bringing the virus into RCHEs, RCHE staff members were required to take RATs daily and undergo nucleic acid tests every other day. Visitors were also required to take nucleic acid tests 48 hours prior to their visits.

Social distancing measures

12. Given that the cap on the number of persons allowed per table in catering premises had been relaxed to 12 starting from 6 October 2022, some members raised concerns about the Administration's justifications for not relaxing the cap on the number of persons allowed in group gatherings in public places ("restrictions on group gatherings") concurrently. Some other members considered that the Administration should extend the business hours of bars, karaoke establishments and nightclubs, and extend the business hours of catering premises in a consistent manner. They also urged the Administration to consider relaxing a series of measures, including the requirement for bar customers to undergo RATs, and the restrictions on the distance between tables and the number of people in catering premises. In addition, some members requested the Administration to consider abolishing the requirement for members of the public to scan QR codes with the "LeaveHomeSafe" mobile application when entering shopping malls, wet markets and supermarkets. Some other members requested the Administration to refine the requirement for wearing masks indoors and outdoors to allow members of the public who had been vaccinated with sufficient doses to eat or drink without wearing masks temporarily in any place where wearing masks was required.

13. After considering members' concerns and views, the Administration announced the following relaxation measures: (a) the restrictions on group gatherings would be relaxed from four to 12; (b) the restrictions on the operating and dine-in hours for catering business premises and scheduled premises would be lifted; (c) for premises in which patrons usually wore masks, the Vaccine Pass requirement would be changed from active checking to passive checking,[1] except that public skating rinks and cinemas (regardless of whether patrons were allowed to exercise or eat and drink without wearing masks) would still be subject to active checking under the Vaccine Pass; (d) holders of the Amber Code would be allowed to enter premises in which patrons would wear masks; (e) with regard to the checking of compliance by patrons of the requirements in relation to the Vaccine Pass and the use of "LeaveHomeSafe", the administrative arrangements for markets managed by the Government would be aligned with the relevant requirements for private markets, i.e. both would be subject to passive checking; and (f) eating and drinking would be allowed at performance venues, spectator stands of outdoor sports premises, as well as outdoor areas of racecourses.

Vaccination

14. Some members urged the Administration to formulate measures for enhancing the vaccination rates of the young and the old. They also raised concerns about the vaccination arrangements for recovered patients and when the Administration would implement the arrangements for administering the fourth vaccine dose on persons aged below 60. Some members also expressed concerns about the failure of some people who had recovered from COVID-19 to apply for the recovery record QR code, and requested the Administration to consider providing members of the public with more choices by introducing vaccines inhaled through the mouth, nasal spray vaccines, or vaccines targeting mutant strains.

15. The Administration advised that the general public were recommended to receive three vaccine doses, and those infected with the disease could be regarded as having received one vaccine dose. It also recommended that persons aged 60 or above who had received three vaccine doses should receive the fourth vaccine dose. As for those persons aged from 50 to 59 who had received three doses of the Sinovac or BioNTech

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[1] In other words, persons-in-charge of these premises would no longer need to actively check patrons' vaccination records or exemption certificates upon their entry. However, patrons would still need to comply with the vaccination requirements under the Vaccine Pass to enter the premises, and present the relevant records or exemption certificates as required by law enforcement officers during spot checks or other enforcement actions.

vaccines, they might receive the fourth vaccine dose at least three months after their last dose. Regarding the difficulties encountered by some members of the public in applying for the recovery record QR code, some of these cases arose from inconsistent personal data of recovered patients and the records in the system, or wrong data entry. The Department of Health ("DH") would strive to provide assistance to the public. As to whether other vaccines would be introduced, the Administration was actively procuring effective vaccines targeting mutant strains, and had collected data of inhaled vaccines from relevant drug manufacturers. When assessing applications, the Administration would consider such factors as the efficacy and side effects of the vaccines.

16. Some members expressed concerns that seven doctors had been suspected of indiscriminately issuing COVID-19 Vaccination Medical Exemption Certificates ("MECs"), which might constitute a loophole in epidemic prevention. They urged the Administration to prevent the recurrence of similar problems and ensure that those members of the public with MECs would comply with the legal requirements. Some other members raised concerns about the failure of the Administration to detect the problem of abuse in issuing MECs in the eHealth system earlier. The Administration advised that legislation had been enacted to provide the legal basis for handling the MECs issued by individual doctors suspected of failing to conduct clinical assessments for patients in accordance with the guidelines issued by DH.

Treatment

17. Members raised concerns as to how the Hospital Authority ("HA") dealt with the epidemic. Some members urged HA to reduce the administrative work of frontline healthcare staff, so that they could focus on taking care of patients. With no increase in the healthcare manpower, some other members raised concern about the impact of the deployment of staff to community isolation facilities on the healthcare manpower of public hospitals. Expressing concern about the status of private hospitals supporting HA in fighting the epidemic, some members also pointed out that private hospitals had different requirements for accepting patients referred by HA, which had greatly increased the workload of frontline healthcare staff. In this regard, some members considered that the Administration might consider including provisions in the licensing conditions for private hospitals to specify that the Government could requisition private hospital beds under specific circumstances, and taking into consideration whether private hospitals had actively assisted in fighting the epidemic when renewing their licences. Some other members suggested that family doctors should be invited to help provide tele-consultation service to

reduce patients' waiting time for consultation and medicine collection. They also urged HA to enhance promotion of tele-consultation service.

18. HA pointed out that its overall strategy was to concentrate its efforts on caring for those infected who needed to be hospitalized under the multi-tiered triage and treatment approach. Household family members categorized as high-risk groups[2] or those infected without an appropriate and safe living environment[3] would undergo isolation at community isolation facilities, while other infected persons would be subject to home quarantine and be provided with various kinds of support.[4] HA had put in place a four-stage contingency plan. It would activate different stages of the bed mobilization plan in the light of the development of the epidemic and the number of confirmed cases. It would also strengthen the collaborative arrangements with private hospitals to reserve beds and deploy manpower to take care of confirmed patients. In addition, HA would activate community isolation facilities in a timely manner and provide more effective support services.[5] In order to focus resources to fight against the epidemic, non-emergency services of public hospitals would also be adjusted accordingly in the light of the development of the epidemic, so as to mobilize more beds and manpower in fighting against the epidemic.

Risk communication

19. Some members expressed concerns about the lack of a tracing function in the current "LeaveHomeSafe" mobile application, and suggested adopting real-name registration. The Administration responded that the Health Bureau was discussing with the Innovation, Technology and Industry Bureau how the functions of the above application could be improved to help identify confirmed patients. However, it stressed that the level of public acceptance should also be considered.

20. Some members also expressed concern that close contacts of confirmed cases were currently able to go out freely with the Blue Code of the Vaccine Pass and asked why they were not categorized as persons with the Amber Code to prevent the virus from spreading. Some other members raised concerns that some infected persons did not declare to DH and took part in community activities. They enquired whether the Administration would impose penalties on those persons, and take compulsory measures to require them to declare to DH. Some other members also expressed concerns about the Administration's measures in place to prevent persons with the Red Code

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2 Such as the elderly, the chronically ill and infants.

3 Such as designated toilets.

4 They included designated clinics, tele-consultation service, hotline, telephone support services and mobile applications.

5 Such as designated clinics and of tele-consultation service.

under the Vaccine Pass from leaving their isolation locations without permission.

21. The Administration explained that at present, the Red Code was applicable to all confirmed cases, while inbound persons would be categorized as persons with the Amber Code. The Administration would review whether the Vaccine Pass arrangement with the Red Code and the Amber Code would be applicable to other persons. At present, after members of the public with positive RAT results made declarations to DH, the QR code of their Vaccine Pass would change to the Red Code, and an isolation order would be issued to them. Currently, there were legislative provisions to deal with persons who violated the isolation order and deliberately spread the virus.

Drug treatment

22. Some members expressed concerns about the status of using COVID-19 oral drugs, when they would expire, and whether HA would consider prescribing such oral drugs to people aged under 60 and introducing Azvudine, a cheaper oral drug, for treatment of COVID-19.

23. HA advised that the existing stock of the oral drugs was sufficient for patients, and they were prescribed to people aged under 60 who belonged to high-risk groups. HA had been monitoring the expiry dates of the oral drugs and would give priority to using those oral drugs that would soon expire.

Support for recovered patients

24. A number of members requested the Administration to strengthen the provision of health maintenance services to recovered adult and child patients to improve the post COVID-19 condition ("long COVID").

25. The Administration advised that data on long COVID, including the number of people affected, their symptoms, their treatment and remedies were being collected worldwide. The Administration would closely monitor the data. Regarding the support for recovered patients, apart from the "Special Chinese Medicine Outpatient Service" provided by the 18 Chinese medicine clinics cum teaching and research centres of HA, the Chinese Medicine Development Fund also provided funding support to Chinese medicine organizations to launch special support schemes. Under such schemes, Chinese medicine practitioners in the private sector were subsidized to provide no more than 10 free Chinese medicine consultation sessions to recovered COVID-19 patients who had been discharged from hospitals or had completed isolation.

Healthcare manpower

26. Members expressed grave concern about the problem of healthcare manpower shortage. In this connection, some members supported the Administration to explore mandating by way of legislation qualified doctors to serve in the public healthcare institutions for a specified period. Some members also expressed support for the admission of qualified non-locally trained dentists and nurses by way of legislation, and suggested that the existing legislation be amended appropriately by making reference to the Medical Registration Ordinance (Cap. 161) for more flexible admission of non-locally trained healthcare and multi-disciplinary healthcare personnel (such as physiotherapists and radiographers).

Arrangements for the Clinical Examination of the Licensing Examination for non-locally trained doctors

27. A number of members were strongly dissatisfied with the Medical Council of Hong Kong ("MCHK") for having cancelled the Clinical Examination of the Licensing Examination ("LE") for non-locally trained doctors four times between 2020 and May 2022 on the grounds of the epidemic, which had aggravated the problem of shortage of doctors. Pointing out that local medical students could continue to attend the examination during the epidemic while non-locally trained doctors could not come to Hong Kong to attend the examination, they criticized MCHK for its double standards. They also questioned whether MCHK had made such decisions to protect the interests of local doctors.

28. MCHK explained that the decision of cancelling the Clinical Examination should be made more than two months beforehand, so that applicants could make necessary arrangements for returning to Hong Kong to attend the examination in a timely manner. During the period of time when the epidemic was severe, there were great difficulties in reserving venues and recruiting the required personnel. Moreover, it took a long time to do the preparatory and wrap-up work for a Clinical Examination.[6] MCHK pointed out that local medical students were continuously assessed during the six-year study period, but this formative assessment could not be adopted in LE as candidates came from different regions. Therefore, only brief examinations could be conducted. Changing the existing

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[6] The relevant work included arranging for the admission of different patients and sorting out the patients' medical history, physical check-up and other check-up results. Also, it was necessary to continue to treat the patients concerned after the examination.

examination method required long-term discussion, and candidates should be given sufficient advance notice.

29. Some members suggested authorizing other institutions to conduct the relevant examination, and increasing the annual number of sittings or quotas of candidates who could seat for each examination. In addition, some members suggested that the Administration should withdraw MCHK's power to approve the admission of non-locally trained doctors so as not to allow MCHK to control the number of doctors in Hong Kong. The Administration advised that in order to solve the problem of shortage of doctors, it was necessary to adopt a multi-pronged approach and act in accordance with the relevant legislation in force. As a statutory professional body, MCHK had the statutory function to conduct LE to enable non-locally trained doctors to obtain full registration in Hong Kong. MCHK would continue to closely monitor the development of the epidemic and review the arrangements for LE in a timely manner. In this regard, the Administration would continue to keep close liaison with MCHK and the medical schools of the two universities, with a view to exploring the feasibility of increasing the examination quotas and/or the number of sittings, thereby ensuring that MCHK was able to continue to discharge the above statutory function.

Medium of instruction as a criterion for the Special Registration Committee to assess non-local medical programmes

30. Under section 14F of Cap. 161, when determining the list of recognized medical qualifications, one of the factors that the Special Registration Committee ("SRC") would consider was whether the medium of instruction was broadly comparable to the two local medical schools (i.e. Li Ka Shing Faculty of Medicine of the University of Hong Kong ("HKU's Faculty of Medicine") and Faculty of Medicine of The Chinese University of Hong Kong ("CUHK's Faculty of Medicine"). In this regard, the Panel discussed with the Administration, SRC and the two medical schools the aforesaid criterion on the medium of instruction.

31. A number of members pointed out that the amendments to Cap. 161 made in 2021 were intended to attract more quality non-locally trained doctors ("NLTDs") to practice in Hong Kong to solve the problem of shortage of doctors, and the medium of instruction of recognized medical programmes was irrelevant to the quality of doctors. They further pointed out that Cap. 161 did not provide that the medium of instruction of the medical programmes recommended for recognition by SRC had to be English. Given that the policy of biliteracy and trilingualism had all along been adopted in Hong Kong, if SRC only recognized non-local medical qualifications acquired from programmes

taught in English, holders of Mainland medical qualifications who were not taught in English in the relevant programmes would be unable to practise in Hong Kong through the special registration route.

32. Regarding the actual medium of instruction of the two medical schools, both medical schools advised that the medium of instruction for their programmes was mainly English. English was used in classes, examinations, publishing articles and learning how to write medical records. Students used Cantonese only when learning to communicate with patients. Medical students of HKU's Faculty of Medicine were required to study in different places and use the local languages during their third year of study (i.e. the enrichment year).

33. In response to members' enquiry about whether the two medical schools would object that English was not the only medium of instruction for their programmes, the two medical schools gave their view that not only English was used in their medical programmes. They indicated that the medium of instruction should not be SRC's only factor when considering medical qualifications and emphasis should be put on the quality of NLTDs instead. HKU's Faculty of Medicine was of the view that when assessing medical qualifications, SRC should focus on whether the programmes and standard of non-local medical schools were broadly comparable to the two local medical schools.

34. Regarding the proportion of using Chinese and English languages in teaching in the two medical schools (including in learning to communicate with patients), CUHK's Faculty of Medicine advised that it would not quantify the proportion and stressed that passing on knowledge and learning to communicate with patients were complementary to each other. Classes, tutorial sessions and clinical teaching were equally important.

35. SRC advised that with new information obtained from the aforesaid discussion, SRC would take appropriate follow-up actions at its meeting. Some members requested SRC to report the outcome of its discussion to the Panel.

<u>Dental care services, review of oral health goals and relevant staffing proposal</u>

36. Some members suggested that the Government should conduct a comprehensive review of dental care services and the scope of review might include: (a) whether the Civil Servants Dental Service would be made available for public use, and insurance would be taken out for civil servants so that they could use private dental care services; (b) whether additional general outpatient clinics for dental services would be provided; (c) whether

public dental hospitals or clinics providing, among others, filling and denture services would be established; (d) whether health vouchers for teeth scaling and polishing or dental examination (valid for one year) would be introduced under the Elderly Health Voucher Scheme ("the EHV Scheme"); (e) whether mobile dental vehicles would be arranged to provide dental care and education services for the elderly in the community; (f) whether the Jockey Club Children Oral Health Project would be regularized; (g) whether financial incentives for dental care would be provided for adults; (h) whether the outreach dental services would be extended to residential care homes for persons with disabilities; and (i) whether the demand for dental services would be alleviated through public-private partnership or collaboration with dental institutes in the Mainland. The Administration advised that it would conduct a comprehensive review of the dental care services provided or subsidized by the Government, including the policy objectives, service scope and service delivery model, and explore making dental services as part of the primary healthcare services.

37. Regarding the Administration's proposal of creating one permanent Consultant post to oversee the development, provision and management of the special dental care service catered for people with special oral healthcare needs, a member recognized the necessity of providing the special dental care services and considered that such services should be launched and developed by a team led by a Consultant. As such, he supported the creation of the Consultant post. Nevertheless, the majority of members did not support the Administration's proposal. Raising doubts as to how that post could help solve the problems such as shortage of dentists and inadequate public dental services for elders and children, they suggested that the Administration should formulate a work blueprint and key performance indicators for the post. They also expressed concerns aboutwhether the current workload of the dental services team under DH had reached its full capacity; and whether the special dental care services of which the post would take charge could be absorbed by other Consultants under the existing establishment if the staffing proposal was not passed.

Development of primary healthcare services

38. On the Government's proposal of establishing the "Primary Healthcare Authority", some members suggested that the Authority should focus on the overall development of primary healthcare and be responsible for setting standards, purchasing services and managing the community healthcare networks, while District Health Centres ("DHCs") should coordinate the efforts of various medical service providers in the community in addition to discharging its responsibilities in preventive treatment, disease screening, health education, etc. DHCs should also connect with hospitals to arrange temporary case managers for discharged

patients. Concurring to the concept of "family doctor for all", these members hoped that more family doctors would be involved. They also hoped that there would be policies in the future for family doctors to follow, so as to strengthen the cooperation between specialists and family doctors, between hospitals and the community, as well as public-private cooperation for building a three-dimensional healthcare system. Members also raised concerns about the service scope of DHCs, the public-private partnership model and its effectiveness.

39. In addition, members requested the Administration to provide a timetable for the formulation of a population-based health database and a health record sharing platform for Hong Kong under the Primary Healthcare Blueprint. Some other members expressed concerns about the reasons why the amount of EHVs had not increased in the past five years, whether the Administration would, by making reference to the colorectal cancer screening programme and the breast cancer screening pilot programme, launch a liver cancer screening programme through public-private partnership, how Chinese medicine treatment could be integrated into the clinical services of HA hospitals on a large scale, whether the Administration had assessed the effectiveness of the Voluntary Health Insurance Scheme in alleviating the pressure on the public healthcare system, and whether it would conduct a review thereof.

Mental health services

Advisory Committee on Mental Health

40. The Administration briefed members on the work of the Advisory Committee on Mental Health ("ACMH") in its second term.[7] Concern was raised over the public reaction, the difficulties or resistance encountered by ACMH, as well as the areas requiring attention when ACMH implemented innovative projects. Moreover, given that ACMH had included support for carers as the focus of its work in the coming term, some members raised concerns about whether the personal needs of persons with mental health problems would be neglected as a result. Some other members urged the Administration to consider inviting the Hong Kong College of Psychiatrists, occupational therapists and family doctors to join ACMH.

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[7] The term was from 1 December 2019 to 30 November 2021.

New initiatives/schemes relating to mental health

41. With regard to the Government's new initiatives/schemes relating to mental health, members expressed their concerns and views as follows:

(a) regarding the mental health promotion and public education initiative "Shall We Talk", some members suggested that if members of the public were rated as having severe mood distress upon completion of the Psychological Distress Test on the thematic website of "Shall We Talk", they should be invited to leave contact information for further follow-up by the Administration. Some members also suggested enhancing the thematic website so that social workers, counsellors, psychologists, etc. can make use of the platform to write reports and provide referral services, etc;

(b) some members expressed concerns about the general waiting time for child patients participating in the Pilot Scheme on New Service Protocol for Child and Adolescent with Attention Deficit Hyperactivity Disorder and Comorbidity (targeting children and adolescents with autism or attention deficit/hyperactivity disorder ("ADHD")) to receive the first treatment, and whether the Pilot Scheme would be extended or regularized in the future. In addition, given that it took time for children suffering from autism or ADHD to wait for public health services and the fees for private services were high, coupled with the fact that class suspension amid the epidemic had caused greater distress to children and parents, some members expressed concerns about whether the Administration would allocate more resources to help the children and parents concerned;

(c) regarding the Mental Health Initiatives Funding Scheme, some members suggested that the Administration should subsidize voluntary organizations on a long-term basis to make use of call systems that supported voice input and intonation recognition to provide emotional support services for persons with mental health needs, and should make good use of technology; and

(d) members supported the proposed amendments to the Declaration of Mental Hospital (Consolidation) Order

(Cap. 136B), [8] and some members requested the Administration to enhance community metal health support services.

Persons with mental health needs in the community

42. Some members expressed concerns about how the Administration could identify persons with potential mental health issues in the community, and how it could strengthen social workers' follow-up work on persons recovered from mental illness in the community, including ensuring that they took medicine on time. Considering that mental health services in Hong Kong were not systematic, some members expressed concerns about whether the Administration would coordinate professionals such as doctors, psychologists and social workers to establish a mental healthcare system in the community. To this end, these members raised concerns about whether DHCs would provide services offered by psychiatrists and clinical psychologists for persons with mental health needs and refer them to private medical service providers, and how DHCs and the Integrated Community Centre for Mental Wellness operated by the Social Welfare Department would coordinate and refer patients.

Legislative proposal to amend the Supplementary Medical Professions Ordinance (Cap. 359)

43. While some members supported the preliminary legislative proposal put forward by the Administration to amend the Supplementary Medical Professions Ordinance (Cap. 359), some members expressed their concerns and views as follows:

(a) on enabling direct provision of services by physiotherapists and occupational therapists to patients without a doctor's referral, some members considered that the Administration could explore the implementation of a pilot scheme to first allow physiotherapists and occupational therapists to

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[8] The objectives of the proposed amendments are to: (a) include Ward D102 of Block D at the Castle Peak Hospital in the declaration for the Hospital as a mental hospital under section 3 of the Mental Health Ordinance (Cap. 136) for the detention, custody, treatment and care of mentally disordered persons; (b) remove the second, third and seventh floors of Block G as well as the second and seventh floors of Block H at the Kwai Chung Hospital from the declaration for the Kwai Chung Psychiatric Observation Unit as a mental hospital; (c) remove Wards H5 and K5 on the fifth floor of the Special Block of the Pamela Youde Nethersole Eastern Hospital from the declaration for the Pamela Youde Nethersole Eastern Psychiatric Observation Unit as a mental hospital; and (d) include Ward 1DL on the first floor of the Main Block of the Tai Po Hospital in the declaration for the New Territories East Psychiatric Observation Unit as a mental hospital.

directly treat patients' symptoms which had been previously diagnosed by doctors. Some members also raised concern that physiotherapists and occupational therapists might not have received training in diagnosing diseases, but some other members indicated that such therapists had received relevant professional training and foreign studies had confirmed that related misdiagnosis cases were not common. Some members also opined that the Administration should contemplate whether all newly graduated physiotherapists could provide services for patients without doctors' referral and what types of treatment could be allowed to dispense with the referral arrangement;

(b) on making continuing professional education a mandatory requirement for renewal of registration for the five categories of supplementary medical professionals under Cap. 359 (i.e. optometrists, physiotherapists, occupational therapists, radiographers and medical laboratory technologists), some members expressed concerns about whether the Administration would require those supplementary medical professionals to have relevant clinical experience as well; and

(c) on enabling Chinese medicine practitioners ("CMPs") to refer patients to radiographers and medical laboratory technologists for diagnostic imaging and laboratory tests, some members pointed out that currently the syllabi of many undergraduate degree courses in Chinese medicine already included knowledge such as imaging and radiology, and suggested that continuing training courses could be provided for CMPs as a threshold for allowing them to refer patients.

Infrastructure and facilities for public healthcare and healthcare teaching

44. The first 10-year Hospital Development Plan has entered its seventh year since its commencement in 2016. In this session, the Panel examined in detail three projects under the Plan. They were the main works for the redevelopment of Prince of Wales Hospital, phase 2 (stage 1); the main works for the redevelopment of Our Lady of Maryknoll Hospital ("OLMH"); and the main works for the redevelopment of Grantham Hospital, phase 1. Members supported the implementation of the projects.

45. Some members considered that accident and emergency ("A&E") services or 24-hour outpatient services should be introduced in the redeveloped OLMH, and some members suggested identifying another site

for the construction of an acute hospital. Some other members expressed concerns about whether the Administration would improve the accessible facilities outside OLMH during its redevelopment for pedestrians to enter and leave the hospital. They also raised concerns about whether the redevelopment of OLMH had fully utilized the plot ratio under the redevelopment plan of OLMH to increase the number of beds in the hospital. Concern was also raised over the impact of the redevelopment projects on patients' rest and healthcare personnel's work. In addition, some members requested the Administration to undertake that the Queen Elizabeth Hospital would remain open and provide A&E, medicine services, etc for the public upon completion of the new acute hospital in the Kai Tak Development Area. Some other members also raised concerns about whether the healthcare manpower in Hong Kong was sufficient to cope with the healthcare development, whether the Administration would consider altering the design when constructing or redeveloping hospitals to cater for the possible outbreak of infectious diseases in the future, and whether the Administration would consider stepping up the development of telemedicine. Some members expressed concern about the excessively long waiting time for the specialist outpatient service at public hospitals, whether the Administration had any short-, medium- and long-term plans to alleviate the manpower shortage, and how much waiting time was expected to be shortened after implementing the plans.

46. Members also supported the two projects relating to medical infrastructure and facilities and expressed their concerns and views as follows:

(a) regarding the project to reprovision the Victoria Public Mortuary ("VPM"), some members raised concerns about whether VPM has the capacity to provide cross-district assistance if other mortuaries were full, and whether its storage capacity could be further increased to meet unexpected needs. They also raised concerns about whether new management modes would be adopted after the reprovisioning of VPM to prevent errors in handling bodies. Concern was also raised as to why the project would take four and a half years to complete, and the impact of the reprovisioned mortuary on the traffic assessment of the area; and

(b) as for the general outpatient clinic ("GOPC") and child assessment centre ("CAC") on Ko Chiu Road, some members requested the Administration to compress the construction time for the project. Some other members suggested the Administration should reserve some space in

the GOPC for future expansion to accommodate other services and to expand the space within the clinic. Also, some members suggested that the Administration should listen more to the views of the community on the pedestrian accessibility of the GOPC and CAC, ease the traffic flow in the vicinity of the project, and step up communication with nearby schools in relation to construction noise.

47. In addition, the Panel also invited the Panel on Education to jointly discuss the enhancement of healthcare teaching facilities of University Grants Committee-funded Universities, including the funding proposal for the enhancement of facilities cum medical campus development (Phase 2) of the University of Hong Kong ("HKU"). Members in general supported the funding proposal. Some members expressed concern that HKU's proposal to construct a new academic building (including laboratories) at the "Green Belt" area located east of No. 3 Sassoon Road had aroused worries among nearby residents about the proximity of the building to residential buildings and the risk of bacterial transmission. These members requested the Administration to give an account of the planning progress of the project, and whether the university had measures in place to allay residents' worries. Some members also expressed concerns about the manpower supply of healthcare professionals, and the adequacy of medical ethics education in the medical schools of the universities, especially in the aspects of professional conduct, awareness of the rule of law and political stance. Some other members requested the universities to strengthen the commitment of medical students to serving the community.

Meetings held

48. During the period between January and November 2022, the Panel held a total of 11 meetings. It will hold another meeting on 9 December 2022 to discuss surveillance, prevention and control of melioidosis as well as the measures for the prevention and control of COVID-19 in Hong Kong.

Council Business Division 4
Legislative Council Secretariat
29 November 2022

Appendix 1

Legislative Council

Panel on Health Services

Terms of Reference

1. To monitor and examine Government policies and issues of public concern relating to medical and health services.

2. To provide a forum for the exchange and dissemination of views on the above policy matters.

3. To receive briefings and to formulate views on any major legislative or financial proposals in respect of the above policy areas prior to their formal introduction to the Council or Finance Committee.

4. To monitor and examine, to the extent it considers necessary, the above policy matters referred to it by a member of the Panel or by the House Committee.

5. To make reports to the Council or to the House Committee as required by the Rules of Procedure.

Appendix 2

Panel on Health Services

Membership list for the 2022 session*

Chairman	Hon Tommy CHEUNG Yu-yan, GBM, GBS, JP
Deputy Chairman	Hon CHAN Hoi-yan
Members	Hon Starry LEE Wai-king, GBS, JP Hon CHAN Kin-por, GBS, JP Dr Hon Priscilla LEUNG Mei-fun, SBS, JP Hon Mrs Regina IP LAU Suk-yee, GBM, GBS, JP Hon Michael TIEN Puk-sun, BBS, JP Hon CHAN Han-pan, BBS, JP Hon Stanley LI Sai-wing, MH Dr Hon David LAM Tzit-yuen Hon LAM So-wai Dr Hon Dennis LAM Shun-chiu, JP Hon Duncan CHIU Hon YIU Pak-leung, MH Hon LEUNG Man-kwong, MH Hon Edward LEUNG Hei Hon CHAN Pui-leung Hon Kingsley WONG Kwok, BBS, JP Hon YANG Wing-kit (Total : 19 members)
Clerk	Mr Colin CHUI
Legal adviser	Ms Wendy KAN

* Changes in membership are shown in the **Annex to Appendix 2**.

Annex to Appendix 2

Panel on Health Services

Changes in membership
(Year 2022)

Member	Relevant date
Hon Alice MAK Mei-kuen, BBS, JP	Up to 18 June 2022

Changes in Membership of the Legislative Council