立法會
Legislative Council

LC Paper No. CB(3)978/2024

Ref : CB3/PL/HS

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 2024 session of the Legislative Council ("LegCo"). It will be tabled at the Council meeting of 11 December 2024 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 20 members, with Hon CHAN Hoi-yan and Dr Hon David LAM Tzit-yuen elected as Chairman and Deputy Chairman respectively. The membership list of the Panel is in **Appendix 2**.

Major work

Primary healthcare development

Establishment of Primary Healthcare Commission

4. Members generally supported the Administration's establishment of the Primary Healthcare Commission ("PHC Commission") to manage the provision, standard setting, quality assurance of primary healthcare services and training of primary healthcare professionals, as well as to plan primary healthcare services and allocate resources by way of strategic purchasing through the Strategic Purchasing Office under the Health Bureau ("HHB").

5. Taking the view that the Administration should do a better job of education to minimize the misuse of accident and emergency ("A&E") service, some members suggested that there should be no additional charges if members of the public were referred to A&E departments by primary healthcare or general practitioners. Some other members suggested the Administration to optimize pharmacists in the community and develop community pharmacies to alleviate the manpower shortage in the public healthcare system. The Administration advised that it was reviewing the fees and charges for public healthcare services and would consult various sectors in a timely manner. The Administration agreed that while considering fee adjustments, it was necessary to properly address the issue of primary healthcare services. Meanwhile, General Outpatient Clinics services would be redesigned to accord priority to the disadvantaged groups. It was also hoped to strengthen the professional-led pharmacy services by setting up a drug formulary and to establish community pharmacies providing sound pharmacy services through the development of information systems. The Administration was actively discussing with the trade on the related issues.

Development of a Joint User Complex with a District Health Centre ("DHC") and update on DHC Expresses

6. Members generally supported the Administration's proposed development of a joint-user complex (including the provision of a DHC within the complex). Expressing concern about the long time and high cost for the development of the complex in five years, some members queried the appropriateness of the choice of the site. Some other members enquired whether the size of the building could be further increased to provide more welfare facilities.

7. Furthermore, some members urged the Administration to enhance publicity on DHC services and draw reference on the Mainland's community health service centres for provision of additional services. Some other members expressed concern about the shortage of venues for holding activities at DHCs. Members also considered that DHCs could not address the primary healthcare needs of the public if they only provided information of private doctors.

8. Some members suggested that the number of ancillary service points should be specified in the service contract of DHCs and that a target utilization rate should be set. There was also a suggestion that more mental health support services should be provided at DHCs/DHC Expresses, and that different assessment tools should be used to provide mental health assessment for the public in the pilot project to be launched at the three DHCs.

Update on Chronic Disease Co-Care Pilot Scheme

9. A question was raised as to whether the current public participation rate of the Chronic Disease Co-Care Pilot Scheme ("CDCC Pilot Scheme") was comparable to the Administration's expectation, and whether the rate of nearly 40% of the participants with confirmed diagnosis of high blood glucose, diabetes mellitus or hypertension after screening was seriously high. Some members, however, expressed concern on whether data on the age group and district of residence of the participants would be analysed. There was also a suggestion that the Administration should invite participants who had been screened and diagnosed to participate in the publicity programme.

10. Noting that only a small number of family doctors in individual districts participated in the Scheme, some members hence expressed concern about the incentives to attract doctors to participate. Some members, however, reflected that frontline healthcare professionals considered that many details of the Scheme could be improved. Some doctors also preferred to prescribe more expensive drugs under the Scheme. Therefore, they enquired whether consideration would be given to introducing a tiered charging mechanism for drugs.

11. Some members enquired whether Chinese medicine ("CM") services would be included in the CDCC Pilot Scheme. The Administration pointed out that in line with the "Family Doctor For All" concept, it was appropriate for the same family doctor to be responsible for post-screening treatment and follow-up, and hence only Western medical practitioners were included in the Scheme for the time being. In response to members' enquiry, the Administration advised that it was considering to extend the Scheme to include more diseases.

12. As regards the adequacy of the nursing manpower in DHCs to meet the needs of the confirmed patients under the Scheme, the Administration advised that at present, about 70% of the confirmed patients under the Scheme had been arranged to meet with nurses for relevant follow-up actions, and the Administration would procure outside nursing services in future to meet the demand. As to whether participants of the Scheme could be provided with tele-consultation and medicine collection services, the Administration pointed out that no tele-medicine would be provided under the Scheme for the time being, and past experience had shown that tele-medicine might increase manpower cost.

Outcome of the public consultation on tobacco control strategies and next-phase measures

13. The Administration updated members on the outcome of the public

consultation on tobacco control strategies and outlined the next-phase tobacco control measures. While some members expressed support for the measures, some other members raised concerns on individual measures.

14. Pointing out that while the smoking prevalence rate in Hong Kong was already lower than that in most overseas regions, the tobacco control measures proposed by the Administration were more stringent than those in most overseas regions, some members queried that the relevant measures might be too extreme. Expressing worry that the measures might affect the incentive of tourists or professionals and talents to come to Hong Kong, some members suggested the Administration to strike a balance between promoting tobacco control and economic development. The Administration responded that it had drawn reference on the experience of many places worldwide in formulating tobacco control measures, taking into account their enforceability, effectiveness and public acceptability. With the World Health Organization estimating that the global economic loss due to tobacco products amounted to US$1,800 billion per annum, and Hong Kong's estimate exceeding $8 billion per annum, the health benefits of investing resources in tobacco control could not be ignored. The Administration expected that the relevant tobacco control measures would, on the one hand, enhance smokers' motivation to quit smoking and, on the other hand, prevent non-smokers (especially young people) from taking the first puff of cigarettes. The Administration further pointed out that most of incoming visitors were here mainly for the purposes of doing business, experiencing the local culture and savouring delicious food, etc. Non-smokers were in the majority and it was believed that a cleaner Hong Kong would be more attractive to them.

15. While some members supported a ban on flavoured cigarettes, some other members considered that smokers were deprived of the right to choose. Some other members, however, expressed concern on whether a total ban on flavoured cigarettes would be replaced by an additional duty. Expressing worry about measures such as increasing tobacco duty and banning flavoured cigarettes might aggravate the problem of illicit cigarettes, some members were concerned about the implementation details of the duty-paid cigarette labelling scheme, including enforcement feasibility. The Administration pointed out that tobacco companies added flavouring agents to their products to mask the harshness of tobacco smoke, thereby reducing smokers' awareness of the hazards of tobacco, particularly among young people and women, and attracting them to try smoking. At present, flavoured cigarettes had been banned in 27 members of the European Union, Canada, the United Kingdom and certain states in the United States. A number of local surveys reflected that after the measure had come into effect, the smoking prevalence rate among young people had dropped, and the number of people attempting to quit smoking and the success rate had increased as well. As regards the

duty-paid cigarette labelling scheme, the Administration indicated that it was conducting a consultancy study to better understand overseas experience in implementing such scheme with a view to working out the implementation details.

16. Regarding the Administration's proposal to impose a total ban on the possession of alternative smoking products in any form (including for self-use), some members expressed concern about how the Administration would dispose of the alternative smoking products and related devices left in the hands of the public. The Administration advised that there would be a buffer period during which members of the public would be allowed to use up their alternative smoking products or hand them over to the Administration.

17. Pointing out that the Tobacco and Alcohol Control Office ("TACO") of the Department of Health ("DH") only operated in the mornings and afternoons from Mondays to Fridays, and law enforcement officers were often unable to take timely enforcement actions upon receipt of reports of people smoking in statutory no smoking areas, some members expressed concern whether the Administration would deploy additional manpower. There was also a suggestion that technology could be used to assist in law enforcement actions. The Administration advised that TACO would take enforcement actions at night and on holidays, and in recent years, plainclothes enforcement action had been adopted for evidence collection to enhance the effectiveness of enforcement, and a review of TACO's manpower would be conducted after the implementation of the relevant tobacco control measures. The Administration also emphasized that apart from stepping up enforcement, it was equally important to establish a no-smoking culture and atmosphere.

18. Given the recent emergence of chewing tobacco products and snuff powder in the community and in schools, some members expressed concern on whether the Administration would step up its efforts in combating the problem. There was also a view that emphasis should be placed on enhancing education to educate young people about the harmful effects of smoking to prevent them from taking their first puff of cigarettes. The Administration advised that the Hong Kong Council on Smoking and Health had been proactively conducting smoke-free publicity and education in schools, reaching out to more than 10 000 students each year. Considerable achievements had been made. The Administration also pointed out that the import and sale of smokeless tobacco products were already prohibited under the food-related legislation and would be enforced by the relevant Government departments.

Support for assisted reproductive ("AR") services

19. Members generally supported the Administration proposal to provide tax deduction for AR service expenses under salaries tax and personal assessment, subject to a ceiling of $100,000 a year, so as to encourage couples who were infertile or couples with difficulties in conceiving to make use of AR services. As regards the definition of infertility, the Administration explained that for a legally married couple, infertility meant difficulties in becoming pregnant despite having regular sex after one year.

20. A concern was raised as to whether the tax deduction could be extended to illegitimate children. There was also a suggestion that the tax deduction should be deferred until the child was three years old to prevent abuse. Some other members suggested providing tax deductions on a progressive basis.

21. There was a view that HHB should collaborate with other bureaux to encourage the public to have children. The Administration agreed that the issue involved areas such as healthcare, social welfare, family, etc. and the relevant bureaux would discuss together.

Oral health

22. As regards the Interim Report of the Working Group on Oral Health and Dental Care, and the measures to be put forward by the Administration in response to the Report, Some members suggested the Administration to introduce dental care vouchers or dental care services for the elderly to subsidize regular dental check-ups and scaling for the elderly. Some members also pointed out that many elderly people were not aware of the Elderly Dental Assistance Programme ("EDAP") under the Community Care Fund ("CCF"), resulting in low enrolment. Some other members suggested the use of dental vans for provision of dental services to residents in remote areas.

23. The Administration pointed out that as of January 2024, a cumulative total of over 160 000 EDAP applications had been received by CCF. In addition, the Administration would enhance EDAP in the third quarter of 2024 to lift the essential requirement of fixing removable dentures, so as to enable eligible elderly to receive services such as dental check-ups, scaling, extraction and filling without applying for removable dentures. The Administration advised that when considering the provision of government-funded curative dental services, the long-term financial sustainability had to be taken into account. At present, the emphasis was mainly put on preventive dental services, and provision of targeted services

to those having difficulties in obtaining dental services due to financial hardship or high-risk factors. The Administration would give an account of the final report of the aforesaid Working Group, the report of Oral Health Survey 2021 and relevant staffing proposal at the Panel's regular meeting in December 2024.

Public and private healthcare services

Progress of the Hospital Authority's work in resuming the Hospital Accreditation Programme

24. While generally agreeing with the implementation of the Hospital Accreditation Programme, members expressed concern that implementing the Programme would increase the pressure on frontline staff of the Hospital Authority ("HA"). Some members suggested the Administration to localize the Programme to make it more acceptable to staff. Members also expressed concern about the form of patient satisfaction surveys to be used by the Administration for improving hospital quality.

25. Given that HA had invited experts from the research centre which drew up the China's International Hospital Accreditation Standards (2021 Version) ("the International Standards") to pay an on-site consultancy visit to the hospitals, some members expressed concern about the experts' suggestions for improvement and how accreditation could reduce medical incidents. There was also a suggestion that the insurance industry should be briefed on accreditation adopting the International Standards with a view to extending the insurance coverage to accredited hospitals in the Mainland.

Quality and safety of public hospital services

26. As regards the quality and safety system of public hospital services and the recent related work, some members criticized HA for the lack of transparency in the way it currently announced medical incidents, pointing out that many medical incidents were announced at night and that no press conference was held to explain each medical incident. HA agreed that there was room for improvement in the announcement of incidents, and indicated that it had set up the Review Committee on the Management of the Public Hospital System ("Review Committee") to follow up the matter. Press releases on some incidents were issued at night because they had to meet with the families of the patients to explain the incident, and the meeting time was usually in the evening. However, HA agreed that it was not ideal to inform the public too late. HA further advised that it would decide whether to hold a press conference based on the complexity of the incident.

27. Some members expressed concern that it was unconvincing that members of the Review Committee were appointed by HA, and considered that the outcome of the review should be made public. Some members also queried why the Advance Incident Reporting System ("AIRS") implemented by HA had not been reviewed after 2010, and urged HA to regularly review the relevant mechanism. In addition, some members suggested that the Administration should attach importance to cost-effectiveness, link the services of HA with funding, or link medical incidents with the remuneration of the management staff of the HA. There was also a suggestion of setting up a hotline for reporting problems with hospital facilities to facilitate systematic follow-up of cases. Some members believed that the shortage of healthcare personnel would increase the risk of medical incidents and urged HA to take measures to address the problem in the short term. The Administration explained that the Review Committee would report to the HA Board after completing its works. The HA Board would consider the recommendations of the Review Committee and submit a report to HHB. In addition, HA clarified that AIRS was reviewed regularly and explained that the relevant guidelines had not been updated after 2010, which was in line with international practice. HA had taken a series of measures to reduce staff turnover, and it pointed out that staff shortage might not be the main cause of medical incidents. It would review how to improve communication with patients and reduce complaints. The Administration would report on outcome of the review by the Review Committee at the Panel's regular meeting in December 2024.

Update on the operation of CUHK Medical Centre

28. Members noted that on 24 February 2023, the Finance Committee ("FC") approved the Government to grant CUHK Medical Centre ("CUHKMC") 2-year extension of its first government loan repayment, and, subject to review of CUHKMC's financial situation by the Panel, to seek further approval from FC for the remainder 3-year extension.

29. Expressing confidence that CUHKMC would be able to repay the loan in the 5-year extension, some members expected that CUHKMC would consider formulating a contingency plan in case of failure to repay the loan. Some other members expressed concern about the impact of the COVID-19 epidemic and the shortage of nurses on the operation of CUHKMC, and whether the increase in business of CUHKMC in 2023 was related to its internal management and policies. There was also a suggestion that CUHKMC should be allowed to import nurses in the Guangdong-Hong Kong-Macao Greater Bay Area ("GBA") to address the manpower shortage problem.

30. Taking the view that CUHKMC should adopt measures to enhance its bed occupancy rate in order to boost its revenue, some Members suggested that CUHKMC should provide incentives to enhance cooperation with larger local insurance companies and attract more residents and athletes in GBA to use CUHKMC's services.

31. Members also expressed concern that while the income of CUHKMC in the second half of 2023 was 1% higher than the estimate, its operating costs had increased by 3%. They were concerned about what measures CUHKMC would take to control operating costs.

32. Regarding the feasibility of widening the scope of private hospitals to adopt packaged charging, the Administration pointed out that it had already included the requirement of packaged charging in the service lease conditions of two newly built private hospitals, and that relevant clauses would be included in the future new private hospitals, as well as when existing private hospitals were expanded or subject to lease modifications.

The Hong Kong Genome Project

33. The Panel visited the Hong Kong Genome Institute ("HKGI")[1] in May 2024 and discussed the Hong Kong Genome Project at the subsequent Panel meeting. While members were generally very supportive of the Project, they expressed concern about the measures put in place by the Administration to protect the data of HKGI against leakage of personal data, and whether insurance companies would make use of the genetic data for underwriting purposes.

34. Furthermore, members considered that genomic testing would be of great help to patient treatment and drug development. They were concerned about the fee arrangements for genetic sequencing, whether the Project could help the public prevent disease, and whether the relevant drug prices can be reduced through cooperation agreements with pharmaceutical companies if HKGI collaborated with them in the development of new drugs.

35. As regards whether there would be any plan to collect more data on Asians for the establishment of an Asian Genetic Centre or a regional database for South China, the Administration advised that a genomic database would need to be complemented by clinical data. At present, some universities in Hong Kong had been allowed to apply for the transit of human genetic resources from the Mainland to Hong Kong for research purposes under a pilot scheme. The Administration would explore the use

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[1] The aim of the visit was to gain insights into the latest development of implementing the Hong Kong Genome Project.

of the Hetao as a pilot area to examine how to further cooperate with the Mainland to facilitate data exchange.

Digital healthcare record

36. The majority of members supported the five-year plan of eHealth+ (i.e. the next stage in the development of the Electronic Health Record Sharing System ("eHealth"). Given that the plan required non-recurrent funding of about $1.4 billion, some members suggested the Administration to split it into a number of smaller projects to be developed in phases. There were also concerns about the system security and data confidentiality of eHealth+. Moreover, noting that the number of electronic health records currently uploaded by private healthcare organizations accounted for less than 1% of the total number of electronic health records uploaded, some members enquired about the Administration's incentives to be provided to boost the participation rate or even to mandate the uploading of electronic health records by private healthcare organizations.

37. Regarding members' suggestion of integrating the functions of eHealth and HA Go, a mobile application of HA, and linking CM and Western medicine medical records in eHealth, the Administration advised that it would integrate the functions of eHealth and HA Go. In addition, a clinical management system for CM clinics called "EC Connect" had been developed for the CM sector, which could be linked to HA Go, with the target of first sharing with the CM sector at this stage and sharing among different sectors thereafter.

38. As to whether eHealth+ could meet the needs of the public for cross-boundary healthcare services in GBA to achieve the objective of "data following the patient", the Administration advised that the proposed new "Portable eHealth Record" function would allow members of the public to access electronic medical records, including radiological images, through the eHealth mobile application, so as to facilitate them in receiving cross-boundary healthcare services.

Latest progress on implementing the regulatory regime under the Private Healthcare Facilities Ordinance (Cap. 633)

39. Regarding the implementation of the regulatory regime under the Private Healthcare Facilities Ordinance (Cap. 633) and the way forward, a number of members expressed concern about the provision of treatment services by non-medical professionals (i.e. unlicensed medical practice) in pain management centres and health centres, and called for regulation of fake medical institutions, including censorship of undesirable advertisements. The Administration advised that it would actively follow up the case with the

law enforcement departments, and pointed out that if the services concerned involved medical services that must be provided by registered healthcare professionals, they would be regulated by the relevant legislation. In addition, advertisements of the relevant services were also regulated under the Undesirable Medical Advertisements Ordinance (Cap. 231). Upon the commencement of the relevant clinic licences, when section 92 of Cap. 633 was brought into operation to prohibit any premises from using the names or descriptions prescribed in Schedule 8 to indicate that the services provided at the premises were medical services provided by the private sector without legal requirement or permission, consideration would be given to revising the Schedule to bring it in line with present day circumstances. The stakeholders would be consulted in this regard.

40. Members were also very concerned about how to enhance the transparency of fees charged by private healthcare institutions. However, some members were concerned that requiring clinics to list each item of fees may be difficult to enforce. Some other members expressed concern about the mechanism for lodging complaints against private hospitals. In addition, some members were concerned about how the Administration would monitor small practice clinics if they were exempted from the licensing requirement. The Administration responded that Cap. 633 empowered the Secretary for Health to make regulations on fee transparency measures, and it was exploring ways to further enhance the transparency of private healthcare charges so that the public could make informed choices. Currently, two private hospitals had entered into service contracts with the Government, and the hospitals were required to provide a certain proportion of packaged charging services, that was, to cover the medical expenses of patients admitted to the hospitals at a fixed price. The Administration would require newly built or redeveloped private hospitals to comply with the requirements. Cap. 633 established a mechanism for complaints against licensed private healthcare institutions. If the Complaints Committee, upon investigation, found that a private healthcare institution had violated the regulations, the Complaints Committee might recommend follow-up actions, including seeking mediation for the dispute. As for the regulation of small practice clinics, although they were not required to comply with the relevant code of practice issued by the Director of Health, they were subject to the regulations of their respective professions as they could only be run by registered medical practitioners or registered dentists. Cap. 633 also empowered the Director to revoke the exemption of small practice clinics under specific circumstances.

Healthcare manpower

41. Regarding the results of the Healthcare Manpower Projection 2023, some members were concerned about the shortage of doctors.

They noted that some institutions had expressed interest in establishing a third medical school and urged the Administration to consider doing so. Some Members took the view that it would not be difficult to recruit sufficient teaching staff, and that consideration could also be given to using existing hospitals as teaching hospitals. The Administration advised that it adopted an open attitude towards the establishment of a new medical school and began discussions with interested institutions a year ago, reminding them of the relevant points of attention and advising them to consult the relevant stakeholders to ensure that their graduates were qualified to practise. The Administration pointed out that the establishment of a new medical school or medical programme required a number of conditions, including teaching staff, teaching hospitals, etc. In addition, the Administration hoped that the new medical school or medical programme could open up new sources of enrolment and promote the development of medical innovation. About 200 clinical teaching staff would be required for running a medical programme, and there was a global shortage of relevant talent. Existing hospitals did not have teaching laboratories, research facilities, etc., and it was difficult to use them as teaching hospitals.

42. Pointing out that the manpower gap of general nurses would reach 9 500 by 2025, some members expressed grave concern about the situation and enquired about the impact of the shortage of nurses on healthcare services and the measures the Administration would take to address the situation. Some Members also suggested increasing the number of places in the nursing schools of HA and relaxing the eligibility criteria for enrolment in the training programmes for enrolled nurses of HA. The Administration pointed out that after the passage of the Nurses Registration (Amendment) Bill 2023, non-locally trained nurses could be introduced to help fill the vacancies. HA was also reviewing its workflow with the use of technology to reduce the workload of nurses in the hope of alleviating the pressure on manpower.

43. Given that the projection results showed that there was a relative abundance of dental manpower and a surplus would occur after 2040, some members were surprised and questioned the projection method. HA explained that the team adopted the usage of dental services from DH and the data from the Thematic Household Survey of the Census and Statistics Department ("C&SD") on the usage of private dental services to make separate projections on the demand for dental services in both the public and private sectors, which were supplemented by the data of the C&SD's Population Projections to estimate the impact of demographic changes on the demand for dental services. Some members further advised that the current public dental services were insufficient and private dental services were expensive. The abovementioned service usage data could not reflect the actual demand. Therefore, they urged the Administration to expand public dental services and link the demand for dentists to the

population ratio. Some other members considered that the Administration should study the establishment of an additional dental school. The Administration advised that it adopted an open attitude towards the establishment of an additional dental school and would closely monitor the long-term supply and demand of dentists before making a decision.

44. Regarding the shortfall of over 1 000 dental hygienists, the Administration explained that the dental service model was undergoing a transformation, and the demand for dental hygienists was expected to increase significantly as they could take on more work in the future. In addition, since the registration system for dental hygienists was only established after the passage of the Dentists Registration (Amendment) Bill 2024, there might be discrepancies in the manpower data in the past.

45. In view of the relatively abundant supply of CM practitioners, some members suggested enhancing promotion of the integration of CM practitioners into the healthcare system to alleviate the pressure of manpower shortage of doctors. As for the manpower supply and demand of medical professionals such as physiotherapists, occupational therapists and chiropractors, it was expected that a balance would be reached in the next 10 years, and there might even be a surplus of manpower. Some members asked whether the Administration would discuss expeditiously with the business sector on how to adjust the service model to attract manpower, or adjust the number of relevant places. The Administration advised that it was strengthening primary care, and allied health professionals would play a more important role after the change in service model.

Development of Chinese medicine

46. Regarding the Chinese Medicine Hospital of Hong Kong ("CMHHK"), which was expected to commence service in phases by the end of 2025, members noted that a bill relating to the operation of CMHHK will be introduced into the LegCo in due course to make technical amendments to certain ordinances or regulations relating to the daily operation of CMHHK.

47. A concern was raised as to how the Administration would ensure that there would be no delay of the construction of CMHHK. Members also expressed concern about whether there would be an adequate number of CM specialists and nurses available for service provision upon the opening of CMHHK, the salary levels of CM practitioners in CMHHK, the service capacity of the hospital, and how Chinese and Western medicines would collaborate in future in the hospital setting. There were also concerns about the fees and charges of CMHHK and issues related to internship of CM students. Members noted that following up the development of CM hospitals

had been included in the work plan of the Subcommittee to Study Matters Relating to the Development of Chinese Medicine[2] under the Panel.

Mental health services

48. Regarding mental health policy and relevant measures in Hong Kong and the future work plan, some members criticized the Administration for lacking an overall strategy to address mental health issues. Different bureaux had launched different services on their own with fragmented policies, causing duplication and wastage of resources from time to time. It was suggested that a cross-bureaux coordination mechanism be established to integrate resources to address the issue at a higher level. Some other members asked whether the Mental Health Review Report published in 2017 would be updated in the light of the impact of social changes in the past seven years on the mental health of the public.

49. Some members were particularly concerned about the mental health of students. They asked about the effectiveness of the three-tier emergency mechanism [3] and whether it would be extended from secondary schools to primary schools and regularized. Some members also expressed concern whether school-based social workers under the policy of "two social workers for each school" had received relevant mental health training, and whether psychiatric nurses or educational psychologists would be arranged to provide services in schools. They also suggested providing specialist healthcare vouchers for students with special educational needs and setting up a hotline for parents to seek help.

50. Regarding the follow-up work after the occurrence of student suicide cases, the Administration advised that it would commission experts to conduct research on the underlying causes of each case, summarize the "risk factors" (such as peer bullying and family background) and minimize them as far as possible, while strengthening "protective factors", such as promoting the 4Rs Mental Health Charter in schools to help students build a protective network.

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[2] The Panel agreed in July 2024 to Prof CHAN Wing-kwong's proposal to set up a subcommittee to study the development of Chinese medicine, which is currently on the waiting list of subcommittees to be activated.

[3] Under the Three-Tier School-based Emergency Mechanism implemented by the Government in December 2023, schools would give priority to take care of and counsel students with higher suicidal risk through the school's interdisciplinary team in the first tier by providing timely assistance or seeking professional counselling or treatment services for them. If schools had difficulty in deploying manpower, the Education Bureau would assist them to refer the cases to the off-campus support network team organized by the Social Welfare Department in the second tier. The third tier was the last line of defence, providing medical services for students with severe mental health needs.

51. Some members considered that the Administration should take a more proactive approach in identifying high-risk individuals, families, elderly people and ethnic minorities. They also expressed concern about the contents, number of places and qualification of the mental health first aid training to be provided by the Administration for Community Care Teams, as well as the qualifications to be attained after completing the training.

52. Some members questioned the actual effectiveness of the "18111 - Mental Health Support Hotline" given that it received 57,000 calls from the period since its launch in December 2023 to June 2024, but only 250 referrals were made. They requested the Administration to provide a breakdown of the calls received. The Administration advised that the hotline had six to 12 operators at different time slots, which could be increased to 30 if necessary. The hotline received about 300 to 400 calls per day. Some callers had been assessed as high-risk cases with suicidal tendencies, and their emotions had been immediately relieved with the counselling of the operators.

53. Some members were of the view that the use of long-acting injections could help address the problem of patients forgetting to take medication. They suggested collaboration with the Mainland on bulk procurement to enhance Hong Kong's bargaining power. In addition, some members considered that the Administration should adopt an innovative mindset in exploring manpower matching strategies to address the mental health needs of the public, such as importing relevant professionals from outside Hong Kong in areas of music therapy, art therapy, etc.

54. Regarding the Administration's proposal to amend the Declaration of Mental Hospital (Consolidation) Order (Cap. 136B) to include the new location of the relocated Kwai Chung Hospital in the area of the Kwai Chung Psychiatric Observation Unit ("the Unit"), some members enquired about the difficulties of the relocation, and how the hospital would communicate with the patients and their families. Members also expressed concern over the adequacy of new beds and enquired about whether facilities of the North Lantau Hospital Hong Kong Infection Control Centre would be used to alleviate the service demand of the West Kowloon Psychiatric Centre under Kwai Chung Hospital. As regards members' request for the Administration to review the name of the Unit given that the choice of diction of "psychiatric" might deter emotionally ill persons, the Administration advised that it would look into the matter.

Develop into a health and medical innovation hub and reform the Approval Mechanism for Drugs and Medical Devices

55. The Panel in general supported the Administration's work in promoting the development of the Hong Kong Special Administrative Region ("HKSAR") as a health and medical innovation hub, and the related staffing proposals to reform the approval mechanism for drugs and medical devices for the establishment of the Hong Kong Centre for Medical Products Regulations ("CMPR").

56. Members noted that under the "1+" mechanism, holders of registration from one of the recognized drug regulatory authorities for new drugs could apply for registration in HKSAR, on the condition that they could provide local clinical data in compliance with the requirements and information recognized by local experts. Pointing out that the "1+" mechanism required pharmaceutical companies to take the initiative to apply, some members took the view that the Government's role was relatively passive. Moreover, only five new drugs had been registered in the year since the new mechanism was introduced and the number was believed to be too low. They suggested the Administration to take measures to attract more pharmaceutical companies to register new drugs or develop drugs in Hong Kong, so that drug prices could be lowered. Members also expressed concern on whether the new mechanism would cover drugs in the Mainland. Some other members also expressed concern on whether drugs and medical devices that had been approved under the "primary evaluation" approach in the future could be used in GBA through the "measure of using Hong Kong-registered drugs and medical devices used in Hong Kong public hospitals in GBA", and whether reference would be drawn on the practice of the real world data institute in Hainan Province to establish a relevant research institution in Hong Kong to assist drugs and medical devices in obtaining the approval of the National Medical Products Administration. Some other members expressed concern about the number of new drugs approved under the "1+" mechanism that had received CCF funding.

57. The Administration responded that under the relevant mechanism, it would be the pharmaceutical companies responsible for submitting the application, but the Government would intervene at an early stage. Drugs produced anywhere could be registered in Hong Kong under the mechanism as well. DH had organized a number of briefings for pharmaceutical companies to familiarise them with the new mechanism. However, some pharmaceutical companies would need time to prepare and collect sufficient data to meet the requirements under the mechanism. The Administration further pointed out that the price of drugs was affected by many factors. If more drugs were registered in Hong Kong or if procurement volumes increased, it would help lower the cost of drugs. Upon the implementation

of the "primary evaluation" mechanism, drugs and medical devices that had completed clinical trials, approval, registration and clinical application in Hong Kong could enter the Mainland through the "measure of using Hong Kong-registered drugs and medical devices used in Hong Kong public hospitals in GBA". The Administration was reviewing the real world data related to the use of Hong Kong and Macao drugs and medical devices in the Mainland, and the "Greater Bay Area International Clinical Trial Institute" ("GBAICTI") would also make reference to the relevant data. In addition, given the short time that had elapsed since the supply of new drugs approved under the '1+' mechanism, the number of grants would be announced in due course when more data was available.

58. Some members expressed concern about how pharmaceutical companies could obtain local clinical data and local expert recognition to meet the application requirements. Some members were also concerned about how the Administration would optimize the registration system for CM through the establishment of CMPR, and how they would strengthen CM development in medical innovation. The Administration responded that in addition to providing research data on specified patients, registrants could obtain data through clinical trials as well. GBAICTI, which would come into operation in the Hetao area, would serve as a clinical trial support platform to assist pharmaceutical companies in clinical research and development. The Administration further explained that, unlike the approval of Western medicines, DH would directly conduct the primary evaluation based on the information provided by CM manufacturers. The Administration hoped that by establishing CMPR, the regulatory functions for Western medicine and CM and medical devices could be combined to create synergy.

59. Concerns were raised on the overall staffing arrangements and office location of CMPR. Regarding the proposed creation of four directorate posts to be offset by the deletion of four posts, some members asked for details of the posts to be deleted and the responsibilities of the proposed new Chief Electronics Engineer. Members also expressed concern about whether the salary of the newly created post was sufficient to find suitable candidates overseas or in the Mainland. Some other members were concerned about the demand for talent in the development of Hong Kong as a health and medical innovation hub. The Administration advised that initially, more than 420 colleagues from DH responsible for supervising Chinese and Western medicines and medical devices would be deployed to work in CMPR. The preparatory office of CMPR would be set up in Wu Chung House in Wanchai, and a suitable location would be identified for long-term planning. As regards the four Consultant posts for offsetting, the Administration explained that the posts would be released after the restructuring of DH, HA and PHC Commission, and the actual

deployment of the posts were still under arrangement. The proposed Chief Electronics Engineer was an Assistant Controller of CMPR overseeing the management of medical devices. Positions such as Controller of CMPR must be in line with international standards. The Administration would consider hiring overseas talent as needed. The full annual average staff cost of Controller was $4.48 million, which was believed to be sufficient to attract overseas experts.

Prepare for influenza season

60. The Panel discussed the Government's preparations for seasonal influenza at its meetings in June and November 2024. Some members expressed concern on whether the quantity of influenza vaccines purchased by the Government in 2024-2025 would be sufficient to meet the demand. Some members were also concerned about the unstable supply of vaccines in the private market and suggested that the Government should centrally procure vaccines and then provide them to private clinics. There was also a suggestion that the Administration should make good use of CM to combat influenza. The Administration advised that in 2024-2025, the total number of vaccines ordered by the public and private sectors would be 2.2 million doses (including one million doses for the Government), which was believed to be sufficient. The Administration further advised that it would discuss with the sector and study the proposal for central procurement of vaccines by the Government. It would also make good use of CM to cope with influenza, including through Chinese Medicine Clinics cum Training and Research Centres in all 18 districts and calling on non-governmental organizations/private CM clinics to open additional consultation service sessions.

61. Expressing concern about the vaccination status of HA's frontline staff, some members believed that they should set an example by receiving vaccination. Some other members expressed concern that why only 80% to 90% of kindergartens, primary and secondary schools participated in the Seasonal Influenza Vaccination School Outreach Programme, instead of all schools. HA responded that since the start of the influenza vaccination programme at the end of September until early November 2024, more than half of its staff members had received influenza vaccination, and it would continue to encourage its staff members to get vaccinated. The Administration advised that about 300 schools had yet participated in the outreach programme, partly because administrative arrangements could not be made by schools, or parents chose to arrange for their children to get vaccinated at the clinics of their family doctors. The Administration would find out from the schools the reasons for their failure to participate and provide assistance, as well as invite relevant school organizations to help promote the outreach programme.

62. To boost vaccination rates, some members suggested the Administration to provide mobile vaccination vehicles to facilitate eligible persons to receive free vaccinations during work; deploy staff to universities to provide vaccination service for students; provide free vaccination service for non-high risk groups in case of surplus of vaccines; enhance the provision of information on nasal vaccines to schools; and streamline the procedures for vaccination activities organized by district organizations. The Administration advised that it would study ways to facilitate vaccination by the public, including the proposal of mobile vaccination vehicles, and explore ways to reduce the wastage of influenza vaccines. It had refined the vaccination programme for 2024-2025 to allow kindergartens and child care centres to choose freely between injectable inactivated influenza vaccines and live attenuated influenza vaccines, and liaise with school sponsoring bodies to provide them with more information about nasal vaccines. In 2024-2025, there was a significant increase in the number of kindergartens and child care centres choosing nasal vaccines compared to the previous year.

Cross-boundary medical collaboration

63. Members generally supported the Pilot Scheme of direct cross-boundary ambulance transfer arrangement in GBA.[4] Given the Administration's proposal to implement a one-way arrangement for direct ambulance transfer from Shenzhen and Macao to Hong Kong as a start, a number of members urged the Administration to expeditiously extend the Pilot Scheme to cover a two-way arrangement from Hong Kong to Shenzhen and Macao. Some members also expected that the next phase of the Pilot Scheme could be extended to cities such as Guangzhou, Zhongshan and Zhaoqing, in which a larger number of Hong Kong people resided.

64. Some members expressed concern about the adequacy of medical manpower in Hong Kong to meet the demand of incoming patients, while some other members considered that the Administration should explain more to avoid misunderstanding by the public that the direct cross-boundary ambulance transfer service could be used for transferring casualties at the scene of accidents to Hong Kong for emergency treatment, or for patients without special medical needs who wished to come to Hong Kong for medical treatment.

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[4] Under the Pilot Scheme, the Hong Kong University-Shenzhen Hospital and Conde S. Januario Hospital of Macao would be the pilot hospitals on the Mainland and in Macao respectively, liaising with the public hospitals in Hong Kong, and providing direct "point-to-point" transfer of patient service between hospitals in the two places.

65. Some members expressed concern as to whether the Administration would draw up a list of diseases and injuries, etc. for which the direct ambulance transfer service could be used. A concern was also raised about the powers and responsibilities of the Mainland and Macao doctors accompanying the ambulances to Hong Kong, and whether these doctors would be able to provide medical treatment to other people in the event of emergencies such as traffic accidents. Members also expressed concern about the number of ambulances to be deployed to provide cross-boundary transfer service, the cost of each cross-boundary transfer case and which party would bear the cost, as well as the relevant arrangements such as insurance.

Meetings and duty visits

66. During the period between January and November 2024, the Panel held a total of 10 meetings.[5] It will hold another meeting on 13 December 2024.[6] As regards duty visits, apart from visiting HKGI,[7] the Panel also joined the Government's delegation to conduct a duty visit to the ZhongShan Chenxinghai Hospital of Integrated Traditional Chinese and Western Medicine and the Hong Kong University-Shenzhen Hospital.[8]

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5 Including one joint meeting with the Panel on Welfare Services and the Panel on Education.

6 The discussion items for the meeting are mentioned in paragraphs 23 and 27 above.

7 See paragraph 33 above.

8 The purpose of the duty visit was to gain insights into the medical standards, services and facilities of the relevant hospitals and the implementation of the Elderly Health Care Voucher Greater Bay Area Pilot Scheme, and to explore ways on how cross-boundary medical cooperation could be further promoted. The relevant duty visit report is set out in LC Paper No. CB(3)734/2024.

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 2024 session

Chairman	Hon CHAN Hoi-yan
Deputy Chairman	Dr Hon David LAM Tzit-yuen
Members	Hon Tommy CHEUNG Yu-yan, GBM, GBS, JP Dr Hon Starry LEE Wai-king, GBS, JP Hon CHAN Kin-por, GBS, JP Prof Hon Priscilla LEUNG Mei-fun, GBS, JP Hon Michael TIEN Puk-sun, BBS, JP Hon SHIU Ka-fai, BBS, JP Hon Stanley LI Sai-wing, MH, JP Hon LAM So-wai Dr Hon Dennis LAM Shun-chiu, JP Hon Duncan CHIU Hon Edward LEUNG Hei Hon CHAN Pui-leung Hon Judy CHAN Kapui, MH, JP Hon Joephy CHAN Wing-yan Hon Kingsley WONG Kwok, BBS, JP Hon YANG Wing-kit Revd Canon Hon Peter Douglas KOON Ho-ming, BBS, JP Prof Hon CHAN Wing-kwong (Total : 20 members)
Clerk	Mr Colin CHUI
Legal adviser	Ms Doreen WAN